Springfield Medical Centre

[redacted]

384 Liverpool Road, Eccles,
Manchester. M30 8QD
Tel: 0161 871 2450
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[redacted]

Ref:RDJ/ST

19 June 2015

Mr A P Walsh
H M Coroner's Court
Paderborn House
Howell Croft North
Bolton
BL11QY

Dear Mr Walsh,

Your ref: [redacted]

JORGE EMANUEL MOUZINHO ASSABAY E CASTRO – Deceased

We write in response to your letter and report dated 29th April 2015 in relation to the death of Mr Castro.

Springfield Medical Centre has deep regret at the loss of life of Mr Castro and offers its heartfelt condolences to his family. We strive to provide the highest standard of care to all our patients and as patient welfare is our upmost priority we have carefully reflected on your report, which has raised certain concerns. We discussed this significant event at practice level and have sought advice from Greater Manchester Medicines Management Group. We set out our detailed responses below, which includes the introduction of revised procedures and systems, to better support patients, in particular, in the area of prescription monitoring and compliance.

1. Procedures and systems to highlight & alert General practitioners with regard to poor adherence with regular prescribed medication

Springfield Medical Centre had received a letter from [redacted] (consultant in rehabilitation medicine) dated 8th April 2014, which highlighted the issue with "regular adherence with his anti-epileptics". The letter also stated that Mr Castro had been "advised" regarding the need to continue with his

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medication. As a practice we have considered how our IT system can support the practice team in alerting us to similar issues with patients. It is possible for an alert to flag up when any member of staff enters the patient's records and this will now be implemented for any patients who, similar to Mr Castro, are known to have compliance issues with their medication. All practice staff, clinical and administrative, have been advised to inform the practice management team immediately of any patient where compliance issues have been raised by family, carers or any other health care professionals. The management team will then ensure that an alert is activated on the patient's records.

2. Systems and procedures to alert General Practitioners in relation to the issue of prescriptions that are overdue or have not been collected

Mr Castro's social worker had raised concerns regarding his mood on 18th July 2014 and thus an appointment with the General Practitioner was arranged. At this consultation Mr Castro "admitted feeling low at times but denied any suicidal intent or self -harm". Mr Castro declined medication or psychological support and so he was advised how to access help in the future should his symptoms deteriorate. There was a further telephone consultation with the social worker on 22nd August 2014 where she raised similar concerns again regarding his mood. An appointment was arranged but Mr Castro did not attend. On 18th September 2014 Mr Castro attended an appointment with the General Practitioner. He was accompanied by his social worker and on-going issues with low mood were discussed. At this consultation it was agreed to commence antidepressant medication. His regular repeat medication was considered prior to the new prescription being generated but unfortunately the date of last issue was not noted & the IT system did not highlight that these medications were overdue. The issue of epilepsy and compliance with medication was not raised by the patient or the social worker and in fact the social worker confirmed in a courtesy letter the following day that Mr Castro was "able to manage his personal care" including "medication". As a practice we regret that Mr Castro's lack of compliance with medication was not identified during his appointments and we have considered carefully how this may be avoided in the future.

We have sought advice from our IT system providers & the Greater Manchester Medicines Management Group regarding overdue prescriptions. It is possible for all overdue prescriptions to be highlighted on the repeat medication screen. This was in place on our systems when Mr Castro was seen but the timescales set were for 6 months overdue. Mr Castro's overdue prescriptions fell short of this time period at each consultation and thus were not highlighted to the general practitioner. However, we have been advised that it is possible to amend this

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time period and the practice has made the necessary amendments so that in future any staff viewing a patient's prescriptions will be alerted sooner (from 3 months) and appropriate action can be taken to mitigate any risk to the patient. This would include immediate notification to the General Practitioner who would then liaise with the patient, carers, family and pharmacy as appropriate. The practice can then work with all necessary individuals or agencies to help support the patient with compliance of their medication.

However, even this system has its limitations, as it would only highlight the issue of overdue prescriptions when a member of the practice team is actually in the patient's records and looking at the repeat medication screen. As a practice we have over 3000 patients on regular repeat medication. Each prescription is usually for 1 to 2 months duration. However, approximately 300 of these patients, like Mr. Castro, are issued medications on a weekly basis. This system is usually for patient safety or as a compliance aid. We have thus decided to create a register of all patients who are receiving prescriptions on a weekly basis. These prescriptions are issued in 4 weekly batches and the administrative staff will be checking the prescriptions have been issued for each patient every month. Those that have not been issued will be passed to a General Practitioner for review. Weekly prescriptions are all sent to the patient's nominated pharmacy. We have written to our local pharmacies and asked them to kindly inform us if there is any interruption to any of these patients' medication collection or supply.

3. Training of all staff in relation to prescribing

As a practice we have taken this opportunity to look at our prescribing systems and the changes above do require staff training. However, we have also looked at the possibility of external facilitators who may bring further advice and expertise to the practice on effective management of repeat prescribing. We can confirm that a half-day workshop has been arranged for Thursday 25th June and we would be open to any further recommendations on this day.

Once again we are deeply sorry for the loss of life of Mr Castro.

Below is a summary of the changes we have/will be implementing:

1. Alert in patient records if issues with compliance have been raised (with immediate effect)
2. Amendment to IT system so overdue prescriptions will be highlighted sooner (with immediate effect)

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3. Register of patients who are receiving weekly prescriptions (completed but will be updated regularly as more patients are commenced on weekly prescriptions)
4. Notification and discussion of this significant event and collaboration with local pharmacies (completed)
5. Training workshop for all staff involved in repeat prescription generation to support implementation of systems & procedures as above (25th June 2015)

As a practice we hope that the above measures can help to support patients with the compliance of their medication by using a more rapid alerting system together with collaboration with pharmacies and other agencies working with patients and sharing their care.

Yours sincerely

[redacted]

For and on behalf of all partners of Springfield Medical Centre