

## Inspection Evidence Table

Farrow Medical Centre

(1-540948172)

**Inspection Date: 18 and 19 September 2023**

**Date of data download: 23/08/2023**

## Overall rating: Not rated

Farrow Medical Centre was inspected on 20 April 2023 and was rated as inadequate overall and inadequate for providing safe, effective, responsive and well led care. The provider was rated as good for providing caring services. This inspection was an announced focused inspection, carried out on 18 and 19 September 2023.

The purpose of this inspection was to review actions taken by the provider in response to warning notices issued following the April 2023 inspection for non-compliance with Regulation 12, safe care and treatment and Regulation 16, complaints. These warning notices were issued by the Care Quality Commission in April and May 2023 with a compliance date of 1 August 2023 and 1 September 2023, respectively.

This inspection on 18 and 19 September 2023 was not rated.

## Safe

At the inspection in April 2023, the practice was rated as inadequate for providing safe services because we found issues with the management of infection prevention and control (IPC), vaccine refrigerators and recruitment checks. A review of patient clinical records found the provider did not ensure the safe and appropriate management of patient medicines and medicines monitoring.

At this inspection in September 2023, we found that the premises were clean and tidy. The provider could not evidence that daily cleaning checks were carried out, however we saw that monthly audits were undertaken by the external cleaning company to assess the standards of cleaning carried out at the practice, and that these showed good compliance. There was effective management of vaccine handling and storage, and an effective system in place to ensure that recruitment checks were carried out in accordance with regulations. A review of patient clinical records found there were still issues with the safe and appropriate management of patient medicines and, care and treatment.

## Safety systems and processes

**The practice had clear systems, practices and processes to keep people safe and safeguarded from abuse.**

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Y
<p>At the inspection in April 2023, we found that the provider did not consistently apply their own recruitment policy to ensure that 2 references were in place for 2 staff members before they commenced working at the practice.</p> <p>At this inspection in September 2023, we reviewed the records of 3 recently recruited staff members and found all records to be complete. This included Disclosure and Barring Service (DBS) and registration checks, signed contracts and 2 references for each staff member. The provider had obtained references for the 2 staff members identified as not having references in place at the previous inspection.</p>	

## Infection prevention and control

**Appropriate standards of cleanliness and hygiene were met.**

	Y/N/Partial
The practice had acted on any issues identified in infection prevention and control audits.	Y
<p>At the inspection in April 2023, we found that the provider had not acted on all the issues identified in their last infection prevention and control (IPC) audit. For example, the provider had not replaced the fabric blinds in the clinical rooms and had not carried out the required repair to the plaster work of the building, as directed in the IPC audit. In addition, schedules to evidence the appropriate cleaning and decontamination of clinical rooms and equipment were implemented during the inspection.</p> <p>At this inspection in September 2023, we observed the practice to be clean and tidy. Actions identified in the previous IPC audit had been completed. The cleaning schedules were no longer in place, so we did not see evidence of daily cleaning checks being carried out. However, we saw that monthly audits were carried out by the external cleaning company to assess the standards of cleaning carried out at the practice, and that these showed good compliance. We were told that clinicians were given time at the end of each day to clean their clinical areas.</p>	

## Information to deliver safe care and treatment

**Staff had the information they needed to deliver safe care and treatment, but this was not always managed in a timely manner**

	Y/N/Partial
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Y

There was a documented approach to the management of test results and this was managed in a timely manner.	Partial
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	No
<p>At the inspection in April 2023, CQC's GP specialist advisor (SpA) undertook a number of searches of the practice clinical records system and found that the provider did not consistently act upon the clinical information received about blood test results, and use this information to review patient care and keep them safe.</p> <p>At this inspection in September 2023, our searches of the practice clinical records showed that there was a process in place to review test results. However, we identified a small number of results had not been actioned for several days. We raised this with the provider who told us this happened occasionally when they were particularly busy. In addition, results were sometimes filed without appropriate follow-up with the patient.</p>	

## Appropriate and safe use of medicines

### The practice did not have effective systems for the appropriate and safe use of medicines, including medicines optimisation.

Note: From July 2022, CCGs have been replaced with Sub Integrated Care Board Locations (SICBL) and CCG ODS codes have been retained as part of this.

Note: ‰ means *per 1,000* and it is **not** a percentage.

Medicines management	Y/N/Partial
There was a process for the safe handling of requests for repeat medicines and evidence of effective medicines reviews for patients on repeat medicines.	Partial
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	Partial
There was a process for monitoring patients' health in relation to the use of medicines including medicines that require monitoring (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	Partial
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Y
Vaccines were appropriately stored, monitored and transported in line with UKHSA guidance to ensure they remained safe and effective.	Y
<p>At the inspection in April 2023, we found that appropriate or structured medication reviews for some patients with long-term conditions, such as those with thyroid issues, those with diabetic retinopathy or those prescribed multiple medicines had not always been undertaken.</p> <p>At this inspection in September 2023, we saw that there were 202 patients diagnosed with hypothyroidism on the practice's register. We found that 10 patients had not undergone thyroid function tests in the last 18</p>	

months. For the 3 patients that we reviewed in detail we found that medication reviews had been undertaken in the last 12 months. However, there were issues identified with how the practice dealt with those patients who did not respond to requests for undertaking monitoring tests. For example, the practice did not reduce the duration of the medication for these patients.

There were 864 patients diagnosed with asthma on the practice’s register. We saw there were 68 patients who had been prescribed 2 or more courses of rescue steroids in the last 12 months. We reviewed 2 patients and found that both patients had received an adequate assessment at the time of prescribing rescue steroids, and that annual asthma reviews had been undertaken appropriately.

There were 785 patients diagnosed with diabetes on the practice’s register. We saw there were 65 patients with diabetic retinopathy whose latest HbA1c was more than 74mmol/l. We reviewed 3 patient records and found that structured medication reviews had been undertaken.

The clinical searches included a review of patients prescribed 10 or more medicines (polypharmacy) who had not had a medication review undertaken in the last 18 months. We identified 3 patients as not having received a medication review in the last 18 months, and the most recent medication review for 1 of these patients did not involve a review of all required medications.

At the inspection in April 2023, the practice was part of a project to reduce the prescribing of antibiotics to their patients. In January 2023, the Lowering Antimicrobial Prescribing (LAMP) report (specific to GP practices in West Yorkshire) showed an increase in antimicrobial prescribing since January 2020 of 53%. The practice was aware of this but did not have a clear action plan in place to manage this increased antibiotic prescribing.

At this inspection in September 2023, we carried out a review of the latest LAMP report from May 2023 and found that the practice had reduced their antibiotic prescribing to 6.2%, a 42% decrease since January 2023. We saw from clinical meeting minutes that antibiotic prescribing discussions had taken place. The provider had also made changes to their policy to reflect the fact that prescribing for respiratory conditions was to be carried out face to face with patients.

Furthermore, at the inspection in April 2023, the provider did not ensure effective management of the 4 vaccine refrigerators in the practice. Provider records viewed at the inspection showed that out of range temperatures were not reviewed and monitored in line with guidance, and there were gaps in the recording of refrigerator temperatures. Also, some were found to be over-stocked and contained some expired vaccines.

At this inspection in September 2023, we observed the 4 vaccine refrigerators to be clean and not over-stocked. No expired vaccines were found. A review of temperate records showed that temperatures were checked and recorded consistently.

**Track record on safety and lessons learned and improvements made**

**The practice had a system for recording and acting on safety alerts, but this was not always effective.**

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Y

Staff understood how to deal with alerts.	Partial
<p>At the inspection in April 2023, we found that whilst safety alerts may have been initially responded to, the provider was unable to demonstrate that all relevant safety alerts were consistently applied to ensure patient safety. Meeting minutes did not evidence that these were consistently discussed at clinical or nurse team meetings.</p> <p>In April 2023 we found that the provider did not always ensure that women of childbearing age were informed of the associated risks if prescribed teratogenic medicines (Some medicines such as teratogenic drugs are known or suspected to have the potential to increase the risk of birth defect and development disorders when taken during pregnancy.)</p> <p>At this inspection in September 2023, the provider told us they had updated their processes to ensure that all relevant staff were continuously aware of safety alerts. For example, email receipts were requested to ensure that staff had viewed the safety alert each time it was sent to them by the practice's pharmacy team. A review of meeting minutes showed that safety alerts had been discussed at several clinical meetings.</p> <p>Our review of clinical records identified 27 women of childbearing age who had been prescribed teratogenic drugs. A review of 5 of these patients showed that although staff were aware of the risks of teratogenicity, appropriate actions were not always taken. For example, staff had made several failed attempts to contact 1 patient by telephone but had not attempted to advise the patient of the risks in writing. There were 3 patients on long-acting contraception, but they had not been advised of the risks associated with the teratogenic medication. We saw 1 patient was under hospital care but there was no evidence of a risk acknowledgment form in the patient's record. In addition, we identified that for patients prescribed methotrexate (a drug used to treat inflammatory autoimmune conditions like rheumatoid arthritis), the day of the week that the medicine was to be taken had not been recorded, even though this was subject to a Medicines and Healthcare products Regulatory Agency (MHRA) drug safety update issued in September 2020.</p>	

## Effective

At the inspection in April 2023, the practice was rated as inadequate for providing effective services as we found issues with the documentation of do not attempt cardiopulmonary resuscitation (DNACPR) orders.

At this inspection in September 2023, we found DNACPR orders to be complete.

### Consent to care and treatment

**The practice always obtained consent to care and treatment in line with legislation and guidance.**

	Y/N/Partial	
Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented.	Y	

Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Y	
Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decisions were made in line with relevant legislation and were appropriate. 1	Y	
At the inspection in April 2023, we undertook a review of 3 sets of patient clinical notes where a do not attempt cardiopulmonary resuscitation (DNACPR) decision had been recorded and found there had not been an effective review of these decisions and that they had not been documented in line with relevant legislation.  At this inspection in September 2023, we undertook a review of 3 sets of patient clinical notes where a DNACPR decision had been recorded and found that all 3 records had been completed appropriately. For example, there was evidence of discussions carried out with patients, documentation of the setting in which the DNACPR was put in place, and decisions about mental capacity had been recorded. All 3 DNACPR forms had been signed and dated.		

## Responsive

At the inspection in April 2023, the practice was rated as inadequate for providing responsive services as we found that the provider did not have a functioning system in place to effectively manage the receiving, recording, handling or responding to complaints made by patients or other persons. The provider did not use complaints to improve the quality of care.

At this inspection in September 2023, we found that the provider had resolved these issues and had an effective system in place to receive, record, handle and respond to complaints. Complaints were used to improve the quality of care.

### Listening and learning from concerns and complaints

**Complaints were listened and responded to and used to improve the quality of care.**

Complaints	
Number of complaints received in the last year.	32
Number of complaints we examined.	8
Number of complaints we examined that were satisfactorily handled in a timely way.	8
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	0

	Y/N/Partial
Information about how to complain was readily available.	Y
There was evidence that complaints were used to drive continuous improvement.	Y

Example(s) of learning from complaints.

Complaint	Specific action taken
Potential breach of patient confidentiality at the reception desk.	Discussed with reception staff member who was reminded about confidentiality. Discussed at meetings. Apology given to patient.
Patient had issues with ordering their prescription.	Discussed at meeting. Patient advised of alternative ways that they can order their prescription.

#### Any additional evidence or comments

At the inspection in April 2023, the provider did not have a functioning system in place to effectively manage the receiving, recording, handling or responding to complaints made by service users or other persons. A complaints policy was in place, but this was not followed.

At this inspection in September 2023, we found that the provider had a functioning system in place to receive, record, handle and respond to complaints. There was a complaints manager and a complaints officer in place at the practice. The provider had updated their complaints policy and process since the last inspection. We saw that complaints and actions were recorded on the practice's system, and that complaints had been reviewed to identify trends and to make improvements. We saw meeting minutes which showed that complaints had been discussed with the staff team and reviewed consistently.