

# Care Quality Commission

## Inspection Evidence Table

### Fitzalan Medical Group (1-559739083)

Inspection date: 11 June 2018

Date of data download: 11 June 2018

Please note: Any Quality Outcomes Framework (QOF) data relates to 2016/17.

## Safe

### Appropriate and safe use of medicines

Indicator	Practice	CCG average	England average	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU).(01/07/2016 to 30/06/2017)(NHS Business Service Authority - NHSBSA)	0.87	0.96	0.98	Comparable to other practices
Percentage of antibiotic items prescribed that are Co-Amoxiclav, Cephalosporins or Quinolones.(01/07/2016 to 30/06/2017) (NHSBSA)	10.3%	10.3%	8.9%	Comparable to other practices

Medicines Management	Y/N
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.	Y
There was a process for the management of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	Y
Explanation of any 'No' answers: N/A	

Any additional evidence
<p>Due to concerns identified during our February 2018 inspection a warning notice was issued. The warning notice required the practice to improve the monitoring of high risk medicines, the international normalised ratio (INR) results for warfarin by 30 April 2018.</p> <p>At our inspection in June 2018, following concerns raised about the practice, we expanded the inspection to review the acute and repeat prescribing processes.</p>

At this inspection in June 2018 we found that the practice had updated their repeat prescribing processes. For example; a prescriber would record and review patients' INR results prior to the prescription being authorised. We reviewed the results of monthly audits carried out by the practice and patient records and saw evidence that INR results were reviewed prior to the authorisation of the warfarin prescription.

We saw evidence that on-site prescribers generated and authorised acute prescriptions. Patients nominated community pharmacies to receive electronic prescriptions. Patients or their representatives including community pharmacy staff collected paper prescriptions. Prescriptions required following a home visit were generated and authorised at the practice. This allowed for alternative community pharmacies to be used, if required. Although, this could lead to a delay in generating prescriptions when staff were undertaking home visits all day. Administration staff explained that repeat prescriptions were generated within one day of receipt of a request and authorised by a GP after one further day.

Patients and their representatives could request repeat prescriptions via various routes including: web form, email, post or in person. At reception the practice offered patients a copy of their repeat request, a white or yellow form. The yellow form indicated that the patient had less than three days' supply left. Staff told us that all electronic prescription requests were processed by a dedicated prescription team at the main practice. The main and branch surgery each processed the paper requests received at each surgery. If a patient electronically requested a paper prescription for collection at the branch surgery the prescribing team would raise a task on the computer system for staff at the branch surgery to action.

Staff told us that repeat prescriptions were issued for one or two months' supply and could be requested up to six times before re authorisation by a GP. They explained that the practice was rescheduling annual medication reviews to the month of a patients' birthday. If staff received a seventh repeat request, they could generate a repeat prescription and would also send a task to the patients' usual GP requesting the repeat was reauthorised. A GP told us that when they authorise a repeat prescription for a high-risk medicine they check on the practice computer system for recent blood results. The practice identified 134 patients were prescribed warfarin between 1 May 2018 and our inspection. We randomly reviewed; three patient records and all had recent blood test results recorded on the practice computer system.

Once these changes were embedded, the prescription team manager will be initiating a suite of computer reports. These were to ensure the relevant test results have been recorded and acted on prior to the authorisation of prescriptions for warfarin and other similar high-risk medicines. Tasks and reminders within the computer system were used by staff to check blood tests had been undertaken, results received and appropriately actioned.

The practice received discharge summaries and letter from specialists advising and informing them of changes to their patients' medicines. These were received electronically and by post. On receipt these were added to the patients' records, coded and forwarded the patients usual GP. The GP would review the communication and amend the prescribed medicines. Occasionally, the practice would be contacted by patients or their representatives before the letter arrived, staff would clarify the urgency and forward the urgent concerns to the duty GP. We reviewed the type and volume of correspondence received by the practice and saw evidence that correspondence was handled in a timely manner. There was no backlog of any type of incoming correspondence on the day of inspection.

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

Significant events	Y/N
There was a system for recording and acting on significant events	Y
Staff understood how to report incidents both internally and externally	Y
There was evidence of learning and dissemination of information	Y
Number of events recorded since 1 February 2018 inspection that were related to medicines management.	3
Number of events that required action	2

Example(s) of significant events recorded and actions by the practice;

Event	Specific action taken
A repeat prescription request was declined by GP as the patient required a medication review. The patient should have had enough medicine to last until the medication review but ran out and was admitted to hospital.	<p>The practice identified that this patient may not have been using their medicine correctly.</p> <p>The practice planned to run a search of their clinical system to identify other patients on the same medicine to ensure that they were using their medicine at the expected rate. Patients who were suspected of not using their medicine appropriately would be referred to the practice nurse for follow up.</p> <p>Although this plan was recorded on the clinical meeting minutes there was no learning identified or action plan recorded in the significant event record.</p>
A patient in a residential care home was treated for a urinary tract infection and blood tests were requested. At this time no changes were made to patient's regular medicines.	<p>The results of the blood tests were not received so further blood tests were requested.</p> <p>Further training for GPs was identified, but from the significant event record it was not clear whether the training had been completed.</p> <p>The practice identified that the residential care home should be informed and asked for further information. It was not clear from the significant event record when or whether this has occurred.</p> <p>There was no evidence that the practice had reviewed their own protocols for requesting blood tests for patients in residential care settings.</p>

### Any additional evidence

The practice had recorded a positive significant event following an investigation by NHS England of a complaint they had received about the management of a patient with a complex medical history. The NHS England investigation found several areas of good practice including a clear agreed care plan with prescription requests being checked with a named GP and communication with other care providers co-ordinated by a single GP. We saw evidence that learning from this event had been shared with other staff and clinicians.

We also saw evidence through clinical meeting minutes that older significant events which involved

medicines management were being reviewed and trends identified. For example; there was a significant event where a patient had been issued two prescriptions for an opiate painkiller within a short timescale with no reason for the reissue recorded on the patient's record. A second similar event was recorded so as a result the practice introduced an Opiate Monitoring Policy to ensure that opiate painkillers were not re-issued within a short timescale without GP authorisation and reasons being documented. The policy had only recently been introduced so there was no data available yet to demonstrate its effectiveness.

**Notes: CQC GP Insight**

GP Insight assesses a practice's data against all the other practices in England. We assess relative performance for the majority of indicators using a z-score, a statistical tool which shows the deviation from the England average. It gives us a statistical measurement of a practice's performance in relation to the England average, and measures this in standard deviations. We calculate a z-score for each indicator, thereby highlighting the practices which significantly vary from the England average (in either a positive or negative direction). We consider that z-scores which are +2 or more or -2 or less are at significant levels, warranting further enquiry.

N.B. Not all indicators are part of the GP insight set and those that aren't will not have a variation band.

The following language is used for banding variation:

- Significant variation (positive)
- Variation (positive)
- Comparable to other practices
- Variation (negative)
- Significant variation (negative)

Note: for the following indicators the variation bands are different:

- Child Immunisation indicators. These are scored against the World Health Organisation target of 95%.

It is important to note that z-scores are not a judgement in themselves, but will prompt further enquiry, as part of our ongoing monitoring of GP practices.

Guidance and Frequently Asked Questions on GP Insight can be found on the following link: <http://www.cqc.org.uk/what-we-do/how-we-use-information/monitoring-gp-practices>

**Glossary of terms used in the data.**

- **COPD:** Chronic Obstructive Pulmonary Disease
- **PHE:** Public Health England
- **QOF:** Quality and Outcomes Framework (see <https://qof.digital.nhs.uk/>).
- **RCP:** Royal College of Physicians.
- **STAR-PU:** Specific Therapeutic Group Age-sex weightings Related Prescribing Units. These weighting allow more accurate and meaningful comparisons within a specific therapeutic group by taking into account the types of people who will be receiving that treatment. ( [See NHS Choices for more details](#)).