Care Quality Commission

Inspection Evidence Table

Meir Park Surgery (1-540617623)

Inspection date: 26 May 2020
Date of data download: 20 May 2020

Safe

Rating: Not Rated

Appropriate and safe use of medicines

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

	Y/N/Partial
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	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.	N
There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	N
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	N

Explanation of any answers and additional evidence:
We looked at the clinical records of 22 patients. Records we viewed were not always comprehensive or up to date. We found that there was no oversight of medicine reviews. Clinical records contained minimal information and did not give assurance that appropriate reviews had taken place. For example, a medication review code was added to the clinical records to say a review had taken place however, there was no recorded information of the review. We saw an example where a patient was prescribed a medicine at a higher dosage than that advised in national guidance, there was no record of the clinical decision for this and no record of consideration at the medication review.

We looked at 11 hospital letters, selected randomly, and found four examples where required actions had not been processed, or had been updated incorrectly, for example two of these were requests for medicines to be commenced, these changes had not been made appropriately. Where changes had been made, actions were often completed by administrative staff with no clinical oversight to ensure changes were accurate.

From the records that we viewed, it was not evident that the practice had assured itself that it was safe to prescribe high-risk medicines or that appropriate monitoring of patients had taken place before prescriptions were issued. There was no system in place for the audit of high-risk medicines. We looked at the prescribing of one high risk medicine and found 29 patients had been prescribed it in the last six months, 13 of these patients did not have appropriate blood monitoring recorded in the practice clinical record in line with local and national guidance.

	Y/N/Partial
We saw an example of medicines being prescribed in large quantities. There was no system in place to ensure the quantity of medicines issued were monitored and in line with national guidance.	

Well-led Rating: Not Rated

Leadership capacity and capability

Governance arrangements

There were no clear responsibilities, roles and systems of accountability to support good governance and management. The overall governance arrangements were ineffective.

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	N
Staff were clear about their roles and responsibilities.	N
There were appropriate governance arrangements with third parties.	N

Explanation of any answers and additional evidence:

There was a medicines management policy in place which had been reviewed in April 2020. However, we found that the policy was not embedded within the practice and was not reflective of the process in place. Staff told us that they were aware that at Meir Park Surgery, the policy had not been adopted. This had led to poor medicine management and oversight. The provider had recently acted to address this. They had engaged with a Pharmacy Consultant, who had been commissioned to advise and support the practice with medicines management. They told us the policy was being further developed with the support of the Clinical Commissioning Group (CCG).

There was no process for the management or monitoring of repeat prescriptions. We saw examples of where prescribing was not in line with best practice. A process for setting out minimum standards for issuing prescriptions was being developed to support safe prescribing.

Appropriate and accurate information

The practice did not always act on appropriate and accurate information.

	Y/N/Partial
Staff used data to adjust and improve performance.	N
Performance information was used to hold staff and management to account.	N
Our inspection indicated that information was accurate, valid, reliable and timely.	N
There were effective arrangements for identifying, managing and mitigating risks.	N
Staff whose responsibilities included making statutory notifications understood what this entails.	NA

Explanation of any answers and additional evidence:

The practice acknowledged that the system in place did not offer assurance that actions from hospital correspondence were managed appropriately. They articulated recent changes to the process which were designed to ensure clinical oversight of correspondence where appropriate. This change reflected the practice policy. We saw that a further policy had been developed to authorise administrative staff to complete specific tasks without further authorisation from a GP, additional tasks would appropriately require clinical oversight. Staff we spoke with were aware of the new policy and could articulate their role and responsibility in implementing it.

From the records that we viewed it was not evident that the practice had assured itself that appropriate monitoring of patients had taken place prior to prescribing high-risk medicines.

The practice had recorded three significant events which involved medicines. There was minimal information regarding any investigations or lessons learnt. There was no evidence that changes to processes were being monitored in order to assess compliance. We saw examples of incidents that should have been investigated as a significant event, for example a referral to secondary care which had been missed.