Care Quality Commission

Inspection Evidence Table

Meir Park Surgery (1-540617623)

Inspection date: 9 and 10 September 2020

Date of data download: 08 September 2020

Overall rating: Not rated

Safe Rating: Not rated

At our previous inspection on 26 May 2020, we found that:

- There was an inconsistent approach to medicines management with little clinical oversight.
- There was no system in place to ensure patients received an appropriate medicine review.
- The provider did not demonstrate that patients receiving high-risk medicines were appropriately monitored.
- There was no clinical oversight to ensure hospital correspondence was actioned appropriately.

At this inspection we found that:

- An overall, prescribing clinical lead had been appointed to provide clinical oversight of the management of medicines.
- Policies and procedures had been developed to support appropriate medicine reviews. The practice had started to make improvements in some medicine reviews. However, medicine reviews for patients prescribed controlled drugs had not always been completed.
- There had been some improvement in the monitoring of patients prescribed high-risk medicines however, policies for the monitoring of patients prescribed warfarin were not in place and guidance in Medicines and Healthcare products Regulatory Agency (MHRA) alerts was not always adhered to.
- Systems to ensure clinical oversight of hospital letters informing changes to patients' care and treatment had been put in place. However, the pace of review was slow and below the practice's own target rate of completion.

Appropriate and safe use of medicines

The practice had systems for the appropriate and safe use of medicines, including medicines optimisation however, they were not always adhered to or fully embedded into practice.

Medicines management	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.	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 high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	Partial
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	No

Explanation of any answers and additional evidence:

Following our previous inspection in May 2020, we imposed conditions on the practice's registration with the CQC to improve prescribing practices through the appointment of a dedicated prescribing lead and an action plan. At this inspection, we found:

- There had been some improvement in the processes for handling requests for repeat medicines. Policies and processes had been developed to support staff in this process, for example, repeat prescriptions, medicine reviews and long-term condition chronic disease management policies. Clinical and non-clinical staff had received training on these policies and a dedicated GP had been appointed to oversee all repeat prescription requests. Administrative staff were no longer permitted to issue acute prescription requests. Staff we spoke with confirmed this.
- However, we found examples where the policies had not been adhered to. For example, we saw a prescription for a controlled drug had been issued twice on the same day. A significant event analysis completed by the practice demonstrated that policies to prevent the oversupply of medicines had not been adhered to by administrative or clinical staff. This included checking the date the prescription had been previously issued. In addition, alerts within the practice's computer system had been overridden with no explanation documented in the patients' notes.
- Examples where structured medicine reviews for patients on repeat medicines had not been completed. For example, there was no evidence of review or monitoring of two patients prescribed a combination of medicines which were potentially a risk to life.

Following our previous inspection in May 2020, we imposed conditions on the practice's registration with the CQC to identify patients, over a three-month period, whereby hospital letters requesting changes in their treatment or medicines had been received but not actioned. We told the provider they must make the required changes to treatment and medicines in accordance with the instructions contained within the hospital letters and submit regular progress reports to the CQC. At this inspection we found:

- The practice had identified 1,474 patients with a total of 3,359 hospital letters. The practice set a target of reviewing 60 patients per week meaning 360 should have been completed at the time of our pilot inspection. However, they had only completed 175. We found the pace of review of the letters was inadequate. We carried out a review of a sample of the reviewed letters and found

Medicines management	Y/N/Partial

that in some cases appropriate action had been taken. However, we found examples where it had not. For example, required changes in the dose of medicines prescribed and failure to adequately follow up a vulnerable adult.

Following our previous inspection in May 2020, we imposed conditions on the practice's registration with the CQC to improve their prescribing processes for high risk medicines through an action plan. At this inspection, we found:

- The practice had started to implement their action plan and there had been some improvement in their monitoring of patients prescribed high risk medicines for example, methotrexate and lithium.

However, we found examples where national monitoring guidance had not been adhered to. For example:

- A patient had been issued a prescription for two months supply of warfarin before their next blood monitoring was due. Safety netting systems to ensure appropriate blood monitoring were not effective and there was no policy to guide staff on how warfarin should be managed.
- A patient prescribed a medicine for the treatment of rheumatoid arthritis had not received monitoring of their blood pressure or weight.
- We reviewed the records of two patients of child bearing age who had been prescribed a medicine for the treatment of epilepsy. In line with a Medicines and Healthcare products Regulatory Agency (MHRA) alert published in March 2018, they did not have up to date pregnancy prevention plans in place. It was not clear from their records if the required risk assessments had been completed.
- We reviewed the records of two patients prescribed a medicine for the treatment of high blood pressure along with a medicine used for the treatment of high blood cholesterol. A MHRA alert published in December 2014 advised the maximum dose of these two medicines when used in combination. This had not been followed and, there was no explanation within the patients' records.

Following our previous inspection in May 2020, we imposed conditions on the practice's registration with the CQC to improve their prescribing processes for controlled drugs through an action plan. At this inspection:

- We reviewed the records of 14 patients prescribed controlled drugs and found that patients were prescribed high numbers of controlled drugs, medicine reviews had not always been completed and actions requested in hospital letters had not been actioned. There was a lack of evidence in patients' records of trialling alternative analgesia and a lack of evidence that the risks of addiction had been discussed with patients.
- We found that the dose of controlled drugs prescribed for eight patients had not been amended in line with requests in letters from the pain clinic or hospital, three patients had not had a medicine review of the controlled drugs they were prescribed and a controlled drug had been initiated by a non-clinical member of staff and had been issued two-weekly without evidence of clinical review.

Well-led Rating: Not rated

At our previous inspection in May 2020, we found that:

- The governance arrangements for the safe use of medicines were not embedded and did not provide assurance of safe care and treatment.

At this inspection we found that:

- There had been positive changes in the management structure to support the required governance changes. However, we found examples of concern regarding poor medicine oversight, response to correspondence from hospitals and coding of health conditions and treatment within patient records. These demonstrated ongoing systemic governance issues and a failure to fully embed the changes into practice.
- Cultural issues within the practice did not support the delivery of high quality care.

Culture

The practice culture did not effectively support high quality sustainable care.

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	Partial
Staff reported that they felt able to raise concerns without fear of retribution.	Partial
Explanation of any answers and additional evidence: • There had been some improvement in the cohesive working of staff across the two sites. Policies had been adopted across the two sites and nurses and two administrative staff were working at both sites to break down barriers. Staff told us working relationships had improved however, relationships could be difficult at times due to agreement regarding the equity of workload division. Staff told us overall, they felt supported by the management with the exception of when patients were verbally aggressive towards them. Due to the lack of support in this area staff told us they had felt belittled and uncared for by the management team. • To ensure equity of work distribution the GP partners had adopted a strategy of keeping control of their own patients. We saw evidence that this had caused confusion for a locum GP regarding which GP to send a referral to.	

Governance arrangements

The overall governance arrangements were ineffective.

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

There were appropriate governance arrangements with third parties.	No

Explanation of any answers and additional evidence:

At our previous inspection in May 2020, the governance arrangements for the safe use of medicines were not embedded into practice and did not provide assurance of safe care and treatment.

At this inspection we found there had been changes in the management structure to support the required governance changes. The management team were working together and staff reported positively regarding these changes. However, we found examples of concern regarding poor medicine oversight, response to correspondence from hospitals and coding of health conditions and treatment within patient records. These demonstrated ongoing systemic governance issues and a failure to fully embed the new changes into practice.

- The governance arrangements for the safe use of medicines had been reviewed and staff were clearer regarding their role in the management of medicines. For example, non-clinical staff clearly understood that requests for acute prescriptions and changes in medicines requested in hospital letters were only made by a GP. However, we found examples were the policies had not been adhered to by staff. For example, the issuing of a prescription twice on the same day, a lack of medication reviews for patients prescribed controlled drugs, not adhering to MHRA alerts and policies not in place to mitigate risks associated with the prescribing of high-risk medicines such as warfarin.
- Systems to ensure the correct coding of health conditions and treatment within patients' records were in effective. For example, two patients had been coded as pre-diabetic instead of diabetic. There was no evidence in their records they had been informed they were diabetic or referred to the appropriate support services. Another patient had not been coded as diabetic until two years following diagnosis.
- We found other examples where patients' conditions had been coded incorrectly or omitted. For example, there was a lack of coding for patients experiencing poor mental health, and coding had been omitted following administration of an immunisation. Other examples of omissions included a patient who had suffered an extensive deep vein thrombosis and a patient who had suffered a stroke.

Appropriate and accurate information

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

	Y/N/Partial
Performance information was used to hold staff and management to account.	Partial
Our inspection indicated that information was accurate, valid, reliable and timely.	No
There were effective arrangements for identifying, managing and mitigating risks.	No

Explanation of any answers and additional evidence:

Following our previous inspection in May 2020, we imposed conditions on the practice's registration with the CQC to identify patients, over a three-month period, whereby hospital letters requesting changes in their treatment or medicines had been received but not actioned. We told the provider they must make

the required changes in accordance with the instructions contained within the hospital letters and submit regular progress reports to the CQC. At this inspection we found:

- Risks to patients whose care and treatment had not been changed in line with requests within hospital correspondence, had not been mitigated. The practice had identified 1,474 patients with a total of 3,359 hospital letters. The practice set a target of reviewing 60 patients per week meaning 360 should have been completed at the time of our pilot inspection. However, they had only completed 175. We found the pace of review of the letters was inadequate. The practice informed us the work would not be completed until February 2021.

In addition, at this pilot inspection we found that:

- The practice could demonstrate how they had tried to assure the competence of staff following the introduction of new medicine policies. We saw that there was a system in place to monitor when staff had completed the required training. However, we found examples were clinical staff had not complied with the new processes. For example, not using the newly developed medicine review template to ensure high quality medicine reviews and not following processes when reissuing repeat prescriptions. Plans to deal with inconsistent behaviour were being considered.
- There were 562 open tasks sent between staff members of which 306 were marked as priority. We asked the provider why they had not been closed. They told us many of these tasks were duplicates and some were forward dated tasks. They told us they had systems in place to monitor the tasks. However, we found open tasks related to clinical issues dating back to April 2020 meaning, the provider could not be sure that tasks were appropriately actioned or completed.