

Care Quality Commission

Inspection Evidence Table

Newton's Practice (1-547385878)

Inspection date: 05 July 2021

Date of data download: 04 July 2021

Overall rating: Inspected but not rated

Please note: Any Quality Outcomes Framework (QOF) data relates to 2019/20.

Safe

Rating: Inspected but not rated

The practice provided care in a way that did not keep patients safe and protected them from avoidable harm. In that, high risk medicines were not always monitored in accordance with national guidelines.

Appropriate and safe use of medicines

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

Medicines management	Y/N/Partial
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	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.	N

Explanation of any answers and additional evidence:

At our last inspection in July 2019 we found that PGDs had not always been appropriately authorised. At this inspection the practice provided us with the authorisation sheets for their PGDs. We found that out of 24 sheets received from the practice, 12 sheets had been signed and dated by staff after the authorising manager had signed the sheet. This meant we could not be assured that the manager had authorised these staff to work under PGDs.

We discussed the results of our searches and identified a patient that had an unusual dose of a high-risk medicine. The GP was unable to readily identify the reason for this dose and suggested it may have been overlooked when a dose was changed /reduced and the medicines not correctly updated.

We conducted searches of patient records, and some of the results indicated the required monitoring of patients' health had not been carried out. We reviewed a sample of individual patient records. We found patient's health was not always monitored in relation to the use of some medicines, and the clinical records did not always evidence appropriate monitoring and clinical review prior to prescribing.

These searches were indicative of the number of patients potentially at risk due to a lack of monitoring or diagnosis. Risk was not conclusive and further investigation of the patient record was needed to assess the potential risks. A CQC GP Specialist Advisor sampled a select number of patient records, where any risks were potentially identified, to assess the risks for these individual patients.

- Our results indicated that of 14 patients prescribed a particular mood stabilizer medicine two patients had not been monitored appropriately. We viewed the records for these patients, and they had an alert, on their record, to highlight they were on this medicine which requires regular monitoring. We found that both patient records did not have evidence of all the required health monitoring, this included calculation of the patient's BMI and bone profile. For one of these patients there was no record of their health monitoring being checked prior to issuing a prescription. Following the review provider told us that they had found an entry in free text to indicate one patient had an updated BMI calculation on 29/03/2021. This was found within the free text of the patient record.
- Our results indicated that of 54 patients prescribed a diuretic medicine, 13 patients had not been monitored appropriately. We viewed the records for five patients and found two had not had appropriate health monitoring. One of these records indicated that the patient had not had a blood test since 2018. We noted a chasing letter had been sent to the patient in May 2021.
- Our results indicated that of 321 patients prescribed novel oral anticoagulants (NOACs), medicines to reduce the risk of blood clots and stroke, 159 had not been monitored appropriately. We viewed the records for five patients and four of these records did not have evidence of all the required health monitoring. These patients were all overdue creatinine clearance calculations. One further record had no evidence this essential check had been carried out at any point.
- Our results also identified 15 patients prescribed a combination of two medicines to treat high blood pressure and reduce the risk of heart problems. We viewed five records for each of these results. We found no evidence in the records that the patients had been informed of the risks associated with these medicines, as alerted by the Medicines and Healthcare products Regulatory Agency (MHRA) in December 2014. Following our inspection the provider told us that they had found evidence for one patient to confirm they had had a discussion with a GP in 2014 and received advice on this medicine combination from the consultant in 2015.
- Our results indicated that, of ten patients prescribed a medicine for the control of inflammatory arthritis, six had not been monitored appropriately. We viewed the records for these patients and found five patients did not have evidence of all the required up to date health monitoring.
- Our results indicated that, of 129 patients prescribed a medicine to treat high blood pressure, and heart and kidney problems, 129 had not been monitored appropriately. We viewed the records for five patients and found four patients did not have evidence of all the required up to date health monitoring. Blood tests had not been carried out since 2019 for all four patients.

Track record on safety and lessons learned and improvements made

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Y
Staff understood how to deal with alerts.	Y
<p>Explanation of any answers and additional evidence:</p> <p>There were systems for recording and acting on alerts. We saw a spreadsheet that allowed the practice to track each alert as it was received by the practice. A number of these were discussed with staff during the inspection. For example, an alert advising the practice to introduce alert cards for all patients prescribed steroids had been noted, a search of patient records identified those who required the issuing of cards. The practice manager confirmed that this had been actioned and an alert was now on the system to ensure patients newly prescribed these medicines receive a card.</p> <p>We were told that the practice had begun minuting weekly huddle meetings commencing in June 2021 and we saw a record to confirm that new alerts are discussed at these meetings.</p> <p>When reviewing the high-risk medicines alerts, the lead GP told us that, on reflection, when looking at high risk medicines, the ongoing monitoring of medicine alerts for new patients, or where changes to prescriptions take place, could be improved.</p>	