NHS
Suffolk and
North East Essex

CQC INSPECTIONS

Guidance for GP Practices and PCNs in Suffolk and North East Essex

As increasing numbers of CQC inspections are being conducted at GP practices across Suffolk and North East Essex, we have observed that a number of medicines-related areas are commonly identified as requiring improvement.

This document aims to support practices and PCNs in both preparing for an inspection and taking any remedial action required following an inspection.

Remember! to use your clinical system's inbuilt 'help' function for additional support.

Background information

- In collaboration with Ardens, the CQC has developed a suite of clinical searches which are now routinely used when carrying out inspections. GP practices do not need to be subscribed to Ardens to download the searches.
- The searches focus on areas of clinical importance, primarily: safe prescribing, monitoring of higher risk drugs, management of long term conditions and identification of potential missed diagnoses.
- Further information is available here Ardens CQC and here GP mythbuster 12: Accessing medical records during inspections - Care Quality Commission (cqc.org.uk)
- The searches can be used to identify patients who are potentially at risk from not having care delivered in line with national guidance.
- **Caution!** The CQC searches have been specifically designed to identify potential significant risk but they are not intended to be used as a substitute for a practice's own governance systems and processes for managing patient care.

How do I find and run the searches on my clinical system?

SystmOne:	**EMIS Web:**
1. Go to Setup > Users & Policies > Organisation Groups 2. Untick top left box 'Only show groups this organisation has joined' 3. Go to Wiltshire > CQC Inspection Searches 4. Right click > Join Group then turn SystmOne off and back on again 5. Go to Reporting > Clinical Reporting > CQC Inspection Searches	1. Go to www.ardens.live/portal 2. Select "CQC Inspection Searches" followed by the download link 3. Save the folder of searches to your desktop 4. Go to EMIS > Population Reporting 5. Create a new folder called "CQC" and import the downloaded file here

What are the current search categories?

1. Monitoring of patients being prescribed Disease Modifying Antirheumatic Drugs (DMARDs). • See Specialist Pharmacy Service (SPS) guidance on drug monitoring. • See NICE Clinical Knowledge Summary (CKS) for DMARD monitoring	Methotrexate monitoring
	Azathioprine monitoring
	Leflunomide monitoring
2. High risk drug monitoring • See NICE CKS and specific data sheet/licensing requirements	Lithium monitoring
	Potassium sparing diuretic monitoring

	ACE inhibitor or ARB monitoring
	Amiodarone monitoring
	Warfarin monitoring
	DOAC monitoring
3. MHRA/CAS/drug safety update alerts • To ensure the provider has taken appropriate action in response to the alerts.	**a) Single drug alerts:** • Valproate, valproic acid, carbimazole, modafinil and pregabalin - Teratogenicity risk • Hydrochlorothiazide - Skin cancer risks • SGLT-2 inhibitors - Fournier's gangrene risk • Febuxostat - CV risk • Citalopram 40mg or escitalopram 20mg in patients aged >65 - Ventricular arrhythmia risk • Fentanyl patch and no recent opioid prescriptions • Mirabegron BP monitoring • DOAC and mechanical valve
	b) Combination drug alerts: • Potassium sparing diuretic and ACE or ARB monitoring • Clopidogrel and omeprazole or esomeprazole - Reduced antiplatelet effect • Simvastatin 40mg or more and amlodipine, diltiazem or verapamil - Increased myopathy risk • Renin-angiotensin system drugs on two or more - Increased renal risk
4. Potential missed diagnosis:	**Diabetes:** Repeated raised HbA1c >47 on at least two occasions and no coded diagnosis of diabetes. • See NICE CKS diagnosing diabetes.
	Chronic kidney disease (CKD) stage 3-5: Repeated reduced eGFR <60 in the last 2 years (including the latest) and no coded diagnosis of chronic kidney disease. • See NICE CKD diagnosis chronic kidney disease.
5. Medicines usage:	Number of asthmatic patients issued more than 12 Short Acting Beta 2 Agonist (SABA) inhalers in the last 12 months. • See Why asthma still kills 2014.
	The prescribing of gabapentinoid medicines where review is indicated.
	The prescribing of benzodiazepine and 'Z' drugs where frequency of issue warrants investigation.
6. Identification of all patients who have had a medicines review done in the last three months to assess quality of the review process.	
7. Monitoring of high-risk patients with long term conditions:	Patients with CKD stage 4 or 5 who have not had a urea and electrolytes (U+E) test in the last 9 months.
	Patients with diabetic retinopathy with latest HbA1c >74mmol/l
	Asthmatic patients who have been prescribed 2 or more courses of oral steroids in the last 12 months.

	Hypothyroid patients who have not had a thyroid stimulating hormone (TSH) test in the last 18 months.

Medicines-related areas commonly identified as requiring improvement

1. Lack of effective process for monitoring and managing high risk drugs and/or long term conditions:

GP mythbuster 84: Managing high risk medicines in general practice - Care Quality Commission (cqc.org.uk)

GP mythbuster 92: Anticoagulant monitoring in primary care - Care Quality Commission (cqc.org.uk)

- **Remember!** It is the responsibility of the clinician signing the prescription to ensure that all required monitoring is up to date.
- Before issuing and signing a prescription CQC expects the prescriber to:
  - confirm that monitoring is not overdue;
  - check that it is safe to continue prescribing the medicine. This includes reviewing all blood results and/or other required investigations (e.g. BP, pulse, weight etc.);
  - ensure that the quantity of medicine issued does not exceed the date when monitoring is next due;
  - record that they have checked monitoring is up to date prior to issuing the prescription if monitoring checks are not coded in the patient's clinical record;
  - wherever possible, ensure that required monitoring results are coded in the patient's clinical record.

2. Lack of effective process for documenting test results:

GP mythbuster 46: Managing test results and clinical correspondence - Care Quality Commission (cqc.org.uk)

- All tests requested should be documented in the clinical system.
- **Remember!** Blood tests carried out in secondary care should be downloaded from ICE, reviewed, and clearly documented in the patient record.
  - Consider using the 'bloods monitored in secondary care' code which is available in clinical system templates.
  - Clinical system reports are available in Ardens for bloods monitored in secondary care.
- Results should be reviewed in a timely manner and there should be no delays in dealing with results that require prompt action. Clinicians are responsible for ensuring that results which alter patient management are acted on.
- **Caution!** If a patient has had multiple tests and results are received at different times, there is a greater risk that some of the results are not actioned quickly or at all.
- Everyone should be aware of their responsibilities for managing test results. This includes clinicians and administrative staff.

3. Lack of effective process for delivering and documenting structured medication reviews (SMRs):

NHS England » Structured medication reviews and medicines optimisation

- **Remember!** Each PCN must use appropriate tools to identify and prioritise patients who would benefit from a SMR, which must include those:
  - in care homes;
  - with complex and problematic polypharmacy, specifically those on 10 or more medications;
  - on medicines commonly associated with medication errors;
  - with severe frailty, who are particularly isolated or housebound, or who have had recent hospital admissions and/or using potentially addictive pain management medication.
- PCNs are free to use appropriate tools that help them to proactively identify patients from the cohorts outlined above, including the audit and reporting modules in the core GP IT systems.
- NHS England » Structured medication reviews and medicines optimisation see Annex B for 'example tools for audit, identification and analysis of patients for SMRs.'
- PCNs must ensure that only appropriately trained clinicians working within their sphere of competence undertake SMRs.
- An SMR is a structured, holistic and personalised review of an individual who is at risk of harm or medicines-related problems because of their current medicine regimen.
  - **Caution!** An SMR is not the act of re-authorising repeat prescriptions.
  - **Caution!** An SMR is not a review of some specific medicines during a long-term condition review.
  - **Caution!** An SMR is not considered complete until qualified consideration has been given to all the patient's medication.
- Consider using clinical system auto templates to perform and effectively document thorough medication reviews.
- Consider actioning medication reviews via the patient home screen 'patient status alerts'.
- **Remember!** A PCN's Core Network Practices will be required to use the relevant SNOMED codes to record delivery of SMRs, as published in the supporting Business Rules on the NHS Digital website SNOMED CT - NHS Digital

4. Lack of effective process for clear and accurate coding of conditions and their associated medication:

- Patients' records should be appropriately coded to support the effective delivery of care through:
  - appropriate monitoring (and that medicines are not prescribed when monitoring is overdue);
  - provision of advice about their medicines;
  - safety netting in line with guidance;
  - care planning and follow-up where necessary.

5. Lack of effective process for recording hospital prescribed and issued medication:

- **Remember!** To ensure that all outside prescribed medicines are added to the patient record via the drug browser for the purposes of drug alerts and potential interactions.

- **SystmOne process:** Medication – click (?) record a non-printable dental or hospital medication.
    - Additional help is available via clinical system help S1 – help and FAQs – 'Launch TPP learning academy'
- **EMIS Web process:** Add medication – Issue – Change all – Record Hospital – Approve and complete.

6. Lack of effective process for receiving and managing MHRA alerts:

GP mythbuster 91: Patient safety alerts - Care Quality Commission (cqc.org.uk)

- Practices need to monitor updates and alerts and act upon these in a timely manner. They need:
    - systems in place to identify, recall and follow-up affected patients and to review these where required;
    - a process to recall a medicine or device;
    - to incorporate prescribing advice into routine clinical practice - this could be through medication reviews or as part of the practice audit programme.
- The use of technology to monitor and raise alerts is used by many practices to facilitate ongoing safe prescribing.
- **Key points to consider:**
    - Have you ensured that all relevant practice staff are aware of the alert, including the most recent updates?
    - Have you taken action in accordance with the details of the alert? Clinical templates/auto consultations are available for recording actions taken in response to MHRA alerts.
    - Have you recorded this action in the patient record – making sure to reference the alert - even if no further action was required?
    - Have you reviewed the action taken to ensure that affected patients have been identified, contacted and reviewed?
    - Do you have processes in place to check that relevant actions are complete and that no new patients affected by the alert have joined the practice?
    - Consider re-running the search to catch newly initiated patients or the use of clinical system protocols to catch these at the point of prescribing.
    - Do you have a full audit trail of actions taken recorded either via electronic HR systems (e.g. Clarity) or an excel spreadsheet?
    - Consider running searches annually to catch new initiations of a specific drug and to remove recalls if appropriate.

7. Lack of effective process for responding to cohort searches

- With regards to cohort searches (e.g. SGLT-2, hydrochlorothiazide, teratogenic searches etc), CQC are looking for:
    - documentation of discussions or communication with patients about the potential risks highlighted by MHRA alerts;
    - evidence that action has been taken as recommended by the alert and that care and treatment are being delivered in line with this.
- **Remember!** Clinical templates/auto consultations are available for recording actions taken in response to these searches.

- Consider adding a recall to follow up annually or adding a note such as ‘contraception review required as on teratogenic drug’ to an existing recall (medication review/LTC recall etc.).
- **Caution!** CQC do not intend for patients to be removed from the search, as just adding a code to exclude a patient from the search does not mean that the actions recommended in the alert have been taken.