‘Preparing for CQC’ - Forum for Practice Managers & GP CQC leads Workshop 7

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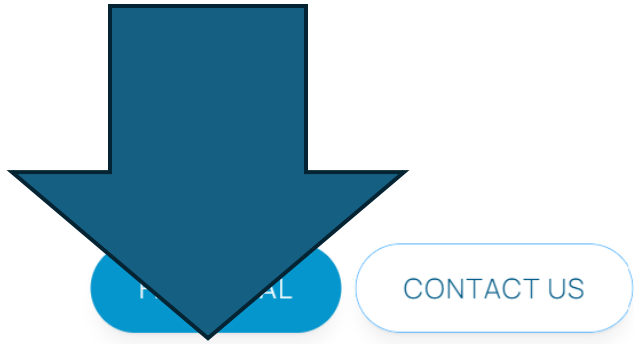
About this session: The content of this session is intended to provide general guidance based on our current understanding of CQC expectations. It should not be relied upon as definitive or exhaustive advice. As CQC approaches and areas of focus may change, practices remain responsible for their own compliance and governance arrangements.

Session 7: Medicines Management

- Ardens CQC searches
- MHRA / CAS alerts process
- Storage of medicines – ambient temp, expiry dates checks
- Sharps

Ardens - CQC Searches



CQC

The CQC has developed a suite of clinical searches which are now routinely used when carrying out inspections of GP practices. They were designed to focus on areas of clinical importance, reflecting the profession's agreed shared view of quality and to contribute to a consistent regulatory approach. The majority of the searches focus on safe prescribing, monitoring of higher risk drugs, management of long term conditions and identification of potential missed diagnoses. They identify cohorts of patients who may require further attention.

Ardens CQC searches:

Ardens - CQC Searches

Not completing these is a significant reason practice can fail a CQC inspection.

Why?
They are medication monitoring based on some old MHRA notices and NICE guidance
CQC will want to see they are as close to 100% up to date – if not view the practice as 'unsafe' for medicines management.

GP mythbuster 12: Accessing medical records and carrying out clinical searches - Care Quality Commission (cqc.org.uk)

Question = But what if they are not up to date when CQC look at them as part of their inspection?

Unfortunately, you will probably fail the medicines management quality statement in your inspection.
An action plan won't work – I know – I have tried this with a practice in an inspection, and they still failed on this!
It then doesn't take much for CQC to drag you down as 'not safe' in the Safe KLOE = high risk of failing inspection.

Some of the Ardens CQC searches – can add new ones - normally in January

GP mythbuster 12: Accessing medical records and carrying out clinical searches - Care Quality Commission

Monitoring patients prescribed DMARDs:
See Specialist Pharmacy Service (SPS) guidance on drug monitoring
- Azathioprine monitoring
- Leflunomide monitoring
- Methotrexate monitoring.

NICE Clinical Knowledge Summary (CKS) for DMARD monitoring

Medicines requiring monitoring:
NICE CKS and specific data sheet/licensing requirements
- ACE (angiotensin converting enzyme) inhibitor or ARB (angiotensin receptor blocker) monitoring
- Aldosterone Antagonist monitoring in patients with heart failure
- Amiodarone monitoring
- Direct oral anticoagulants (DOAC) monitoring
- Lithium monitoring
- Metformin with eGFR less than 30
- Warfarin monitoring.

MHRA/Central Alerting System (CAS)/drug safety update alerts to check provider has taken appropriate action in response

Single drug alerts:

Citalopram greater than 20mg or escitalopram greater than 10mg in patients aged over 65: ventricular arrhythmia risk
DOAC and mechanical valve
Febuxostat: cardiovascular risk
Fentanyl patch and no recent opioid prescriptions
Hydrochlorothiazide: skin cancer risks
Mirabegron BP monitoring
SGLT-2 inhibitors: Fournier's gangrene risk and keto acidosis risk
Valproate, valproic acid, carbimazole, modafinil, topiramate and pregabalin: teratogenicity risk
Combination drug alerts:
Clopidogrel and omeprazole or esomeprazole: reduced antiplatelet effect
Aldosterone antagonist and ACE or ARB monitoring
Renin-angiotensin system drugs on two or more: increased renal risk
Simvastatin 40mg or more and amlodipine, diltiazem or verapamil: increased myopathy risk.

Potential missed diagnosis
Repeated raised HbA1c greater or equal to 48 on at least 2 occasions and no coded diagnosis of diabetes. See NICE CKS diagnosing diabetes
Chronic kidney disease (CKD) stage 3-5 (See NICE CKD diagnosis chronic kidney disease):
repeated reduced eGFR less than 60 in the last 2 years (including the latest), and
no coded diagnosis of chronic kidney disease.

Medicines usage
Asthmatic patients issued more than 12 Short Acting Beta 2 Agonist (SABA) inhalers in the last 12 months. See Short-acting beta 2 agonists (SABA) (salbutamol and terbutaline): reminder of the risks from overuse in asthma and to be aware of changes in the SABA prescribing guidelines
Prescribing gabapentinoid medicines where review is indicated
Prescribing benzodiazepine and 'Z' drugs and where frequency of issue warrants investigation
Prescribing a non-steroidal anti-inflammatory drug over the age of 65 years and/ or an antiplatelet to a patient aged over 75 years without a proton pump inhibitor for gastrointestinal protection
Prescribing a long-acting beta agonist (LABA) inhaler to an asthmatic patient (excluding COPD) in the past 6 months with no inhaled corticosteroid prescribed
Patients with atrial fibrillation and a recorded CHADSVASC2 score greater than or equal to:
1 if male
2 if female
with no anticoagulant prescribed
Combined oral contraceptive pill prescribed to patients with a history of venous thromboembolism
Biphosphonates prescribed for longer than 5 years without an appropriate review or DEXA scan.

Medication review
Identifying all patients who have had a medicines review in the last 3 months to assess quality of the review process (all ages and over 75 years)

Identifying patients receiving 10 or more medicines who have no medication review recorded in the past 18 months.

Monitoring of high-risk patients with long-term conditions
Patients with chronic kidney disease (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 greater than 74mmol/l
Asthmatic patients prescribed 2 or more courses of high dose oral steroids in the last 12 months
Hypothyroid patients who have not had a thyroid stimulating hormone (TSH) test in the last 18 months.

Patients who have had a DNACPR or ReSPECT form completed in the last 2 years
How patients have accessed different types of appointments in recent months.

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GP CQC Inspector and Ardens CQC searches in Full CQC inspections

- The GP CQC inspector will be accessing the CQC searches and looking into the patient's records to check all the monitoring has been completed – normally look back over 3 months
- They will do this in the 2 week period before CQC come into the practice.
- Straight afterwards (or next day), via MS teams, the GP will have their CQC interview and at least an hour of this interview can be discussing findings from the Ardens CQC searches – so in your interest to make sure they are up to date!
- Can ask the inspector if you can have your Meds management lead in for part of that interview
- The CQC GP inspector, samples patient records from all / most Ardens CQC searches and if they look good & up to date, move on. If not, they dive deeper and look at more patient records in each search.
- Remember this is done remotely – you will not be there to explain certain patients and their issues – so the patient's records need to be clear and document all the work you do with these searches.
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GP mythbuster 12: Accessing medical records and carrying out clinical searches - Care Quality Commission

Useful videos / resources on Ardens CQC searches - all short!

GP top tips are focused around the Ardens CQC searches work. Video link here: https://youtu.be/MN8tDlGC1eI
CQC inspection

GP interview: Dr Tomlinson GP partner and registered manager, Medwyn Surgery.

In addition, this is a useful video from the CQC, about the Ardens CQC searches. Go **28 minutes in** to get to the good bit!
Video link here: CQC Clinical Searches Update Webinar – YouTube

From CQC: Clinical searches are currently only available for practices using EMIS (Optum), TPP SystmOne and Medicus. If you use other clinical systems, we will generally review information on the clinical system while we are on site.

But some patients do not engage!

What does CQC want to see with these patients:

- Make sure you document in patient records, your attempts to get the person to attend for the required monitoring etc
- Depending on the risk, consider shortening the repeat prescription amount to encourage engagement.
- Consider documenting the risk in the patient's record: *'the risk of stopping this medication is greater than the risk of non engagement in required monitoring, however further attempts will continue to be made to contact the patient*' - ?code

Overview of Ardens CQC searches – discuss your Practice position 3 monthly (or regularly) in clinical meetings

1. This is an important part that many practices miss

2. Why do your senior management team need a regular update and over view of the Ardens CQC searches position as a practice?

3. Answer: The pharmacists / others are working very hard on these searches but if they have a significant amount to do - it can often slip away from being manageable – can quickly not be on top of them.

4. Its important you know this BEFORE CQC announce your inspection as you cannot 'pull this out of the bag' for your inspection – e.g. if you have 300 patients needing CKD monitoring you have not got enough time / resources to do this in a few days! Plus CQC can see you tried to do this!

5. If Ardens CQC searches have slipped out of control you need to consider what you might have to do as a management team to address this.

6. Consider your 'tolerance' patient numbers (work to do) in each search as a practice – when do you consider you need to do more to address?

Don’t forget the DNA CPR Ardens CQC search!

DNA = Do Not Resuscitate / CPR = Cardio Pulmonary Resuscitation

A yearly review of the RESPECT forms or DNA CPR forms is part of the Ardens CQC searches – a clinician would need to do this – the pharmacist can’t.

Who is doing this search in your practice?

If you have a care home you may have many these forms – check care home patient numbers and forms you have - do they match? If not, are you coding correctly / do you have all the forms?

- Do NOT need to re-do forms every year! Review if they are clinically appropriate & document in patients records – if not clinically appropriate then need to redo the form with patient / family.

- GP mythbuster 105: Do not attempt cardiopulmonary resuscitation (DNACPR) - Care Quality Commission

MHRA (Medicines and Healthcare products Regulatory Agency) & CAS(Central Alerting System) alerts

Make sure you are signed up to both as a practice, and you have a policy as to what you do with them – CQC will ask and this comes up on nearly every inspection.

CAS – Home
Alerts, recalls and safety information: medicines and medical devices - GOV.UK

- Who covers this process when the normal person is on leave – do they know!?
- Up to date policy on how you manage these
- How do the alerts get disseminated to relevant staff?
- What actions do you document (on relevant ones) and where? Use the teamnet log or have your own
- What meeting do the relevant ones get discussed at?
    - GP mythbuster 91: Patient safety alerts - Care Quality Commission (cqc.org.uk)

Security of Blank Prescription Forms – what does CQC say?

CQC are sometimes keen on this…or not – depends on inspector! GP mythbuster 23: Security of blank prescription forms - Care Quality Commission

Why do you think CQC check this?
What they look for:

- Stock stored securely, at least in a locked cabinet within a lockable room or area.
- Access to forms restricted to authorised individuals.
- Record kept of pre-printed prescription form stock distribution within the practice including:
    1. the serial numbers (some are not in order anymore so can't use first and last number!)
    2. where, when (date/time) and to whom prescription forms have been distributed

- Records kept of prescription forms that are:
    1. returned to stock,
    2. destroyed, and the reasons for destruction

CQC says: It is not advisable to leave the forms in printer trays when not in use or overnight.
The new guidance says all prescriptions should be removed from printer trays and locked away when not in use or out of hours

Fridge and Room Temperatures

Fridge Temperatures:

- Need a year's worth of at least daily temperature checks with NO GAPs
- Use fridge data loggers – make sure you download when full – still need daily checks documented
- Cold Chain info poster for every fridge (see next slide) plus this one too Keep your vaccines healthy poster and magnet - GOV.UK
- Make sure vaccines / stock does not touch the side of the fridge – air flow
- Keep fridge locked and take key out -CQC walkabout!
- Make sure all staff checking fridge temps know maximum temperatures and what to do cold chain breech

GP mythbuster 17: Vaccine storage and fridges in GP practices - Care Quality Commission (cqc.org.uk)

Room Temperatures (where drugs are stored) – why log?

Storing medicines at ambient temperatures – SPS - Specialist Pharmacy Service – The first stop for professional medicines advice

- Do not need to do daily (except in hot weather) – you decide how often
- Note maximum temperature on log and action to take if outside range e.g. move to room with air con.
- If no air con – consider ambient fridge if your coolest room is not cool enough!

Put this poster laminated on every fridge – Erika has a copy

What is a cold chain breach?

A cold chain breach has occurred if vaccines are exposed to temperatures outside the 2°C to 8°C range for more than 20 minutes

What should you do if you discover a cold chain breach has occurred?

Keep your cool and follow the steps below

1. RESTORE

Restore the affected vaccines to between 2°C and 8°C as soon as possible and label them as *not to be used.* You may have to move them to a different fridge.

2. REPORT

Report the breach to the NHSE Screening & Immunisations Team (SIT) by emailing england.surreysussexsit@nhs.net We can offer guidance and support.

3. CALCULATE

Calculate the duration of the breach and note the maximum temperature reached using your data logger. If you do not have a data logger, calculate the duration from the last time the fridge temperature was recorded as being between 2°C and 8°C until the time that the vaccines were restored to between 2°C and 8°C.

NHS England

4. CONTACT

Contact the manufacturers of the affected vaccines. Any vaccines deemed safe for use according to the manufacturers' stability data can still be given under a PGD.

5. COMPLETE

Complete a stock incident form on ImmForm *only* if any vaccines are deemed to be unstable and you are advised to dispose of them. Stock incident forms on ImmForm are for recording lost doses of vaccine, not for reporting cold chain incidents.

https://www.gov.uk/government/publications/vaccine-incident-guidance-responding-to-vaccine-errors

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Sharps

Did you know there is an ICB funded needlestick service for all clinicians in GP Practices in Sussex?

Contact Erika for more info / first poster only -display near sink

Need to buy this one or have your own version or maybe sharps bin manufactures can send you a free poster??

Other checks

You will need to DOCUMENT the checks you make of:

- Expiry dates of drugs
- Expiry dates of consumables e.g. dressing packs etc – do not need to list every item! But you need to log / document 'all stock checked and correct' – suggest 6 monthly
- Some practices use QR codes for this – records in clarity
- Emergency equipment and expiry dates of all consumables – document the checks

- See here for CQC suggested list of equipment & drugs to keep: GP mythbuster 1: Emergency care in general practice - Care Quality Commission

- If you decide not to keep all drugs listed you will need a documented risk assessment as to why not – e.g. can be obtained from local chemist quickly if required etc

- Would advise not to keep controlled drugs (unless GP dispensary) as lots of additional checks and documentation required – are you doing this – CQC will check!

PGD's and PSD's
Patient Group Directions and Patient Specific Directions

CQC always look at the folder they are in and check:

Are they up to date and do you have the ones that cover the vaccinations / medication administered?

Will always check the nurse signature and the counter signing (normally GP) signature DATES

Why?

If a new nurse is added and the GP does not re-sign and date then the dates are not correct.

GP mythbuster 19: Patient Group Directions (PGDs)/Patient Specific Directions (PSDs) - Care Quality Commission (cqc.org.uk)

Reflection on today

What will you take away and implement or change in your GP Practice?

Please write in the chat