The Reality of a CQC Inspection

Hayley File – Medicines Inspector

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Learning Outcomes

- Demonstrate knowledge of the CQC's 5 key questions and how these link to medicines optimisation
- Discuss how services who perform differently can impact the patient
- Know how pharmacy technicians can support the patient to have a safe and effective transfer of care
- Identify areas in your own workplace where pharmacy technicians can make a difference

Our 5 key questions

Safe?

What we want to know:

Are there robust systems and processes in place for obtaining, prescribing, recording, handling, storage, security, dispensing, administration and disposal of medicines?

- Are there appropriate policies and procedures in place?
- Who handles medicines? Are they qualified and competent?
- What pharmacy support is offered within the service?
    - Wards
    - Care homes
    - GP practices

Safe?

We ask:

- What is their track record of safety?
- Do staff understand their responsibilities to raise concerns, report incidents and near misses?
- Are incidents investigated thoroughly?
- Are lessons learned and improvements made when things go wrong?
- How is learning shared within the pharmacy team, across the service and externally?
- Is there a culture of openness that encourages reporting and sharing?
- Are people who use the service told when things have gone wrong?

Safe?

We ask and observe:

Do people receive their medicines as prescribed?

- How are people supported to take their medicines?
- Do people receive information about unlicensed medicines?:

Storage and security

- Temperature monitoring
- Expiry date checking
- Controlled Drug management

Emergency drugs

- What is kept? What safety checks are there?

Effective?

- How is effectiveness measured?
  - Audits?
  - Patient outcomes?
- How are current evidence-based guidance, standards, best practice and legislation used to develop how services, care and treatment are delivered?
- How is peoples' pain assessed and managed effectively?
- How effective is the communication during transfer of care?

Caring?

We observe:

Medicines administration

- Is patients' privacy and dignity maintained?
- Is it caring?
- Patient counselling
- Can people access the pharmacy team?

Understanding of people

- Are staff aware of peoples' social situation and what extra support they might need?
- Are people listened to?
- How is independence promoted

Responsive?

Is the care person-centred?

Can people self-administer?

Is information about medicines available in different languages?

What adaptions are made when dispensing to enable people to take their medicines?

- Large print labels
- Compliance aids

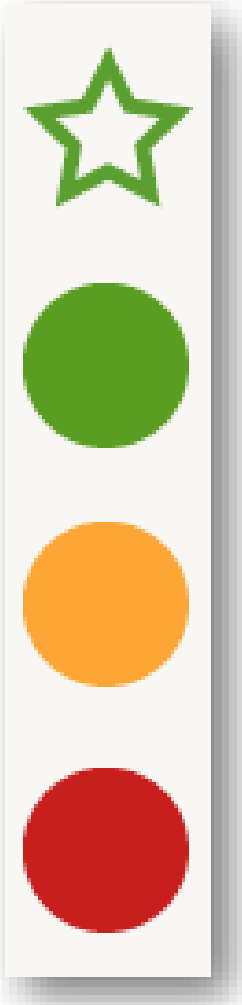
How does the service respond to complaints and suggestions?

Well led?

How do staff ensure the service is safe, effective, caring and responsive???

- Promoting an open culture
- Disseminating information – meetings, forums etc.
- Encouraging improvement and innovation
- Are staff listened to and able to challenge management?
- Do staff feel supported/empowered to do their role?

What do the overall ratings mean?



Outstanding
The service is performing exceptionally well.

Good
The service is performing well and meeting our expectations.

Requires improvement
The service isn't performing as well as it should and we have told the service how it must improve.

Inadequate
The service is performing badly and we've taken action against the person or organisation that runs it.

Workshop - Meet Ted

Ted's Experience of Primary Medical Services

Requires improvement

Are services safe?

- When things went wrong reviews and investigations were not thorough enough and lessons learned were not documented or communicated widely enough to support improvement.

- We found that the practice did not have any robust and effective systems in place for ensuring patients on high risk medicines or those that required regular monitoring were actively followed up in line with national guidance.

Ted's Experience of Acute Hospital Services

Inadequate

Are services safe?

We checked four prescription charts and one chart showed a missed dose for a critical medicine. This had not been picked up by staff on the ward. Additionally the dates of administration of medicines were not always written on prescription charts. This meant medicines to be administered for a specific period could be missed or administered for a period longer than prescribed.

Ted’s Experience of Adult Social Care

Inadequate

Are services safe?

Effective systems were not in place to order people's medicines; some people had not received their medicines because they were out of stock.

One person's tablet was crushed and given to them in a yogurt.
t . Advice had not been obtained from a pharmacist to check if medicines could be prescribed in a different form, such as a liquid medicine if people had problems swallowing tablets.

Before our inspection we received concerns that people's pain relief patches were not being administered or came off because they were not applied correctly. Records of when and where patches had been applied were kept, however, checks were not completed to make sure the patches remained in place and there was a risk that nurses would not know if they had fallen off.

Pharmacy Technician Role

Poor practice and communication between the GP practice, hospital, pharmacy and care home meant that Ted did not receive the best outcome from his medicines.

How could you as a pharmacy technician have supported Ted for a better experience.

Making a Difference

What will you do differently in your workplace ?

Volunteers to share their pledge?