CQC outcome for medicines management: an outsider's inside view

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IN BRIEF

- Patient outcomes from medicines management must be the focus of any improvements to practice.
- Joint working with a CQC-experienced pharmacist helps achieve the highest quality required medicines management outcomes within limited resources.
- Specific and bespoke on-site assessments can quickly and simply identify areas for practice action to ensure CQC standards and quality patient outcomes are achieved.

Registered dental practices must achieve all the essential standards of the Care Quality Commission (CQC), whose outcome 9 is focused entirely on the way practices manage medicines. Experience with specialist dental services and other healthcare professions shows that focused assessments with a CQC-experienced pharmacist can deliver quality patient outcomes from safe and effective medicines use, and improve service efficiency, even when resources are limited. Assessments, either online or on-site, can identify areas for improvement in a practice's current medicines management activity and are an efficient way of achieving effective, safe and legal CQC-compliant activity. The provision of training and CPD sessions, and the joint development of robust governance arrangements and supporting documents including Patient Group Directions (PGDs) and protocols, help to embed activities within everyday practice and provide opportunities for staff development.

Whether it's right for the dental profession or wrong, vital for good patient care or unnecessary, registration with the Care Quality Commission (CQC) is inevitable for all dentists who wish to practise legally in England. Part of the condition for continued registration and practice is adherence to their essential standards of quality and safety,¹ which comprise of 28 outcomes developed to help all providers comply with the legislative requirements associated with CQC registration.

The CQC has highlighted that Medicines Management outcome 9 of these standards is of particular importance, and their five-year plan for safe and effective care places medication and the handling of medicines at the top of a list of identified issues requiring specific attention.² In addition, they have already cited concerns with medicines management in over 40 cases where regulatory powers have been exercised to close down care providers,³

so it follows that adherence to Medicines Management outcome 9 of the CQC standards will be a crucial concern for all registered dental providers.

As a pharmacist 'medicines management' underpins all of my work, but for the non-pharmacists I work with it starts out not even as a term that is well understood. There are many definitions in use but the CQC outcome sets it out as the basis for enabling patients to get the right medicine safely at the time they need it, and with the information they need.

It has ten separate elements describing what the CQC expects to be in place so that medicines are handled, administered, prescribed and used safely and effectively. These elements broadly require dental services to:

- Provide appropriate, personalised medicines treatment to each individual patient based on their choices, status and condition(s), including provision of appropriate information such as the risks and benefits of a particular medicine
- Appropriately monitor and review a patient's relevant medicines
- Have in place written procedures detailing how medicines are managed throughout the practice, including controlled drugs such as midazolam:

these must be consistently worked to and regularly reviewed

- Ensure accurate, timely and clear records are kept for medicines management activities
- Hold appropriate and readily available medicines for resuscitation and other medical emergencies
- Learn from errors and incidents relating to medicines use to improve patient care and safety.

None of these are contentious or unfair – they are a simple list of expectations that patients have of their healthcare provider whether that's their doctor, district nurse or dentist. But for the wide range of professions I work with, this is just one outcome of one the many standards, requirements and memoranda they must achieve in their daily practice, and it has become clear more recently that this burden is becoming unacceptable to individual practices and practitioners.

For the last few years I have been heavily involved in reducing this burden by helping practices assess their compliance to medicines regulations – initially the Healthcare Commission's core standard C4d, now replaced by CQC outcome 9 – and then supporting any ongoing remedial actions needed to meet the requirements.

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This role started as part of permanent employment with a large, nine partner GP practice, but has since broadened to include a wide range of community-based services including district and community nursing, prison healthcare, schools, community hospitals, specialist rehabilitation units and special care dentistry.

The assessment process takes multiple forms and a preferred option is pre-agreed with the service to make sure it suits their needs and fits around their clinical service provision. The most comprehensive and ideal assessment method is an on-site inspection, where I use a specifically developed assurance tool to record data on current medicines management activities. The visit involves a mixture of short discussions with staff followed by a review of relevant paperwork and facilities; for dental clinics this usually takes no more than two hours in total.

Where this method is not desirable or practical, I have developed a web-based audit tool so that practices can perform a self-assessment. The comprehensive on-site assurance tool has been split into over 20 bite-sized sections of multiple-choice questions so that at any time, different staff can complete different sections based on their personal expertise, knowledge or simple availability on a given day.

A third method is a mixture of the two – usually a short personal visit to focus on high-risk activities (eg conscious sedation, use of Botox or controlled drugs) with the rest of the assurance process completed as a self-assessment online.

Following assessment, the results are analysed and developed in to an individual site-specific action plan where current activity falls short of CQC expectation: each plan is matched against the CQC outcome as it is written, but more importantly it also reflects the quality patient outcomes that are expected. Staff are then given all the support needed to take the necessary actions, and the process is repeated each year so improvements can be measured and achievements recorded for CQC inspection or Quality Account purposes.

In dentistry, as with all other professions I support, I have found varied quality in medicines management activities, particularly the way medicines are managed to ensure quality outcomes to patients. As part of my CPD training

sessions that can accompany and support the assessment process, staff are asked to consider and suggest practice actions for one of the more straightforward outcome elements, 9H, namely that a service 'ensures medicines required for resuscitation or other medical emergencies are accessible in tamper evident packaging that allows them to be administered as quickly as possible'.

Their answers invariably focus on the practicalities: having tamper-evident packaging for the medicines, keeping them handy and replacing them when they're out-of-date.

Staff are then invited to consider, from start to finish, what happens if they actually use them: to get them thinking about patient outcomes I share with them the details of a real-life dental incident from a local trust. In brief, a patient in status epilepticus was treated with intranasal midazolam, but because it had not been done before by the under-pressure staff involved, administration led to aspiration of the medicine and complications following eventual recovery: despite the in-date medicine being available in a tamper evident box, the patient still did not get the quality outcome expected.

After some discussion – which can often miss the point by starting with 'at least the fit was stopped though...' – staff develop questions themselves to reflect on, including:

- What 'emergency' medicines do we hold and do they cover every medical emergency likely in practice? Do they match current national recommendations?
- Are there clearly defined procedures in place so we know what to give, to whom, when and how?
- Where and how are the medicines procured? Does this adhere to medicines regulations? Is this cost effective?
- How are they packaged, who does this and how are they kept secure but accessible? What about when the surgery is not open? (particularly if holding midazolam)
- Who checks their expiry date and condition? How often are these checks made and how can we prove it is done?
- Who is trained and allowed in law to administer the emergency medicines?

Are they still competent and how do we know?

- What would happen if the emergency was at a time when the right people are not available – what would we do then and does everyone in the practice know to do the same?
- Are there written procedures to cover these considerations?

From what appears to be a straightforward practicality-based sentence in one element, comes a wide reflection of how the practice can best manage these medicines to ensure patients get the best outcome every time.

Donald Rumsfeld infamously described 'unknown unknowns' as the '...things we don't know we don't know' and experience says this is true for medicines management. Professionals I have worked with, including doctors, have on reflection found that this is a topic which they do not always have the necessary skills, expertise and understanding to achieve effectively. Initially though, these same colleagues have met me with denial, resistance and in some cases anger, as they perceived my activity as a threat to their own role or ability. However, their position was always one of an 'unknown unknown', and it is not until we have looked together during the assessment process at the way in which medicines are actually managed in practice, that the known unknowns were identified and remedied, and the benefits of collaborative working became clear.

For my services and I our challenge with CQC outcome 9 has now become two-fold: using results from the assurance assessment to improve patient outcomes in times of reduced resource, and ensuring subsequent changes to practice become embedded so that quality outcomes are instinctively maintained. Good, close working relationships have been pivotal in achieving this, as has medicines focused training for all staff, so that medicines management becomes everybody's business.

I have often been told that this outcome is a 'pharmacy thing' – but it isn't. It is a 'patient thing' – an opportunity for different professions to work together and share expertise and experience to improve the outcomes that patients get from their medicines. Joint working with dental

colleagues has so far seen the development of specific and dentistry-focused medicines management training sessions, robust governance around the management of all medicines, particularly controlled drugs, expert support for teams to develop their own written procedures for medicines management with confidence, the production of a high-quality guideline for using midazolam in conscious sedation that is compliant with national requirements,^{4,5} and the start of Patient Group Direction development for administration of fluoride and local anaesthetic preparations by dental therapists.

Working together has meant safe, effective and legal patient-focused medicines management in practice. A lot has been achieved to improve the quality of patient outcomes – there's still more to do but I'm confident that together it can and will be done.

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