CQC Guidance - Accessing medical records during inspections of GP practices

We have had several questions about the review of medical records during our inspection of GP practices. The main purpose of the review is to assess the quality of care provided by the practice. It is not to assess the individual clinician.

We recognise that there are particular sensitivities about medical records held by GP practices. The relationship between GPs, practice nurses and patients is often a close and long-lasting one, with a very strong expectation of confidentiality. The GP practices' records may include very private and personal information, including information about relationships, mental health and sexual health. Therefore medical records reviews will usually be done by a GP or a nurse on the inspection team.

CQC's powers to access medical records

CQC have powers under the Health and Social Care Act 2008 (the 2008 Act) to access medical records for the purposes of exercising our functions (which includes checking that registered providers are meeting the requirements of registration).

These powers are always balanced against our responsibilities under the Data Protection Act 1998, the Human Rights Act 1998 and the common law duty of confidentiality. It is also vital that we respect and protect the privacy and dignity of patients, and maintain their trust in CQC and in the confidentiality of their records.
We will only use our powers to look at a patient's medical records where there is a necessary reason to do this, and where the intrusion on the privacy of that patient is justified and proportionate and will always refer to and apply the 'necessity test' set out in CQC's Code of Practice on Confidential Information.

This Code of Practice also describes our powers to access medical records in detail.
CQC has produced some guidance on accessing medical and care records within all sectors.

The Code of Practice will always be followed by inspection teams when accessing medical records during inspections of NHS GP practices and GP out-of-hours services.

Due to the particular sensitivities of medical records held by GP practices we have provided some additional information to support inspectors to use the above guidance and to help GP practices prepare for an inspection.

Approach to accessing medical records during inspections of GP practices

Purpose of inspection teams looking at medical records

- We assess the quality of care and corroborate this through the evidence we see in medical records. This includes nursing records. Evidence gathered from looking at medical records will be for the purpose of assessing the quality of care providing using the Key Lines of Enquiry and the underlying prompts. This evidence will be looked at alongside other evidence gathered on the inspection; information we have from the ongoing relationship management we have with the provider, information from Intelligent Monitoring and information gathered prior to the inspection

- Reviewing medical records during a CQC inspection is for the purpose of assessing the quality of care provided by the GP practice. CQC's role is not to assess an individual clinician's ability – if the inspection team comes across particular concerns about an individual clinician, this will be referred to the appropriate person or body e.g. the GMC or the NMC.

- The purpose of the medical records check will be made clear to the practice. At any stage during the inspection we will let the practice know when and why we intend to look at medical records. Practices should be prepared to provide secure and discrete access to the required medical records during an inspection.

- We will always consider the validity and proportionality of looking at records.

Process for looking at medical records

A check of a medical record(s) will usually be undertaken by a clinician on the inspection team. This may be the GP or the practice nurse specialist advisors on the team. Although the 2008 Act does not require this, our view is that in most cases it is appropriate for the clinicians on the team to lead this aspect of the inspection. This will usually be the case but where inspection teams have concerns about a practice it may be necessary for any of the inspectors to access medical records or to see a medical record.

- The number of records our inspection teams look at will vary depending on the evidence we see in the practice and within the medical records. For example, where we have concerns about a particular aspect of care, more records may be requested to be viewed. (For example where patients report not being given appropriate information and advice about their condition or we identify concerns that test results are not being followed up in a timely way).

- CQC's powers allow inspection teams to access people's records without the consent of the people to whom the records relate. Therefore we will not seek consent from people.

- Where appropriate and proportionate, our inspection teams will ask the GP practice to ask the service to select and provide evidence to show that they meet the required standards. If it is proportionate to do so, practices can anonymise records. In each instance our inspection teams will consider, with the practice, whether it is proportionate for the practice to do so: some practices' systems easily allow them to anonymise records but where this is not possible, records can also be anonymised manually.

  A template has been developed for inspection team members to use to record evidence when looking at medical records (see below). We have also provided some examples of the Key Lines of Enquiries (KLOEs) and prompts where it is most likely that our inspection teams will find it necessary to look at medical records in order to make a judgement about the quality of care.

Template for gathering evidence from medical records

Many of the KLOEs can be answered without access to GP medical records; they can be picked up in interviews with staff or through a prepared presentation from the practice at the beginning of the inspection. Our handbook describes our approach and KLOEs

The following template provides a guide to collecting and recording evidence from medical records. Where the inspection team is looking at medical records this template should be used and followed. Where there are particular concerns about a practice then this tool will be used flexibly. In most cases the key lines of enquiry relevant here are:

Practice name: Date of inspection: Inspection team member name:	
Date of consultation: Reason for consultation: Population group:	
Aspect of record assessed	Record of Evidence
Has an adequate assessment of the patient's condition been made as evidenced in the records, based upon history, clinical signs and, where necessary, appropriate examination?	
Is a working diagnosis or clinical impression recorded?	
Have appropriate investigations and/or treatment been provided or arranged?	
If prescriptions were issued, do they match the working diagnosis?	
Have repeat prescriptions been reviewed when altering or adding medications?	
Is care based upon current accepted evidence?	
Do the notes show evidence of advice being given to patients?	
If indicated, has the patient been referred to another practitioner?	
Do the notes show evidence of follow up arrangements where felt to be clinically appropriate	
Have clear, accurate and contemporaneous patient records been kept, including telephone consultations?	