General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Buckinghamshire Healthcare NHS Trust, Pharmacy Department, Wycombe Hospital, Queen Alexandra Road, HIGH WYCOMBE, Buckinghamshire, HP11 2TT

Pharmacy reference: 1029117

Type of pharmacy: Hospital

Date of inspection: 16/09/2019

Pharmacy context

This is a pharmacy in Wycombe Hospital in High Wycombe which provides pharmacy services for patients receiving treatment at the hospital. The hospital has a cancer centre, a children's ambulatory care centre, midwife led birthing centre, a GP-led urgent treatment centre, specialist cardiology and respiratory services, haematology and in-patient stroke care. The main hospital activity is regulated and inspected by the Care Quality Commission (CQC). The main business of the pharmacy is to provide pharmacy services and supply of medicines in the course of the hospital business, and this activity is regulated by CQC. The main registerable activity includes supplying an external renal unit in the same NHS Trust and dispensing and supplying private prescriptions.

Overall inspection outcome

✔ **Standards met**

Required Action: None

Follow this link to find out what the inspections possible outcomes mean

Summary of notable practice for each principle

Principle	Principle finding	Exception standard reference	Notable practice	Why
1. Governance	Standards met	N/A	N/A	N/A
2. Staff	Standards met	N/A	N/A	N/A
3. Premises	Standards met	N/A	N/A	N/A
4. Services, including medicines management	Standards met	N/A	N/A	N/A
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance ✔ Standards met

Summary findings

The pharmacy's working practices are safe and effective. It protects people's private information and keeps most records it needs to by law. People are able to give feedback about the services provided. The team members follow written instructions to make sure they work safely, and they learn from their mistakes. And they understand how to safeguard and support vulnerable people.

Inspector's evidence

There were a range of hospital policies and protocols in place, including standard operating procedures (SOPs). These were reviewed every two years or when there were any relevant changes. They covered the relevant GPhC activity and requirements, including Responsible Pharmacist (RP) regulations. Pharmacy staff had all read through these and signed to confirm they agreed to adopt them. The role of the responsible pharmacist and the associated GPhC activity were outlined in the SOPs, so responsibilities and lines of accountability were clear, and the responsible pharmacist notice was displayed in the reception area. The team also had SOPs for the rest of the dispensary tasks.

Near misses were recorded in a near miss log and feedback provided to the staff who made them. The team would review all the near misses every quarter to highlight any areas of improvement. Dispensing and medications errors or incidents were recorded on DATIX and these were reviewed every month to identify learning points. Individual feedback was given to staff and post incident reflection forms used to document any outcomes. A clinical governance pharmacist provided support and the team aimed to continually develop the service and make improvements. The team held a weekly medicines safety huddle which was led by the pharmacy management team and any key messages or issues would be highlighted in this meeting and shared with all pharmacy staff members. A newsletter regarding the issues in the huddle would also be produced and placed in shared areas so if people were not present for the huddle, they could still benefit.

Patients are able to raise complaints with the Trust through PALS and online, details of how to do this were displayed around the hospital. Most complaints were around the waiting times. The pharmacy had developed systems to minimise these and used an electronic prescription tracking system and a screen in the pharmacy which gave a visual display of the current activity and enabled work to be prioritised.

The pharmacy used a paper responsible pharmacist log book. The responsible pharmacist changed throughout the day and the log had numerous gaps where pharmacists had not signed in, so it was not strictly compliant. The team explained that they usually signed in when they were undertaking registerable activity. The pharmacy used the JAC pharmacy management system to record medication supplies. Supplies against private prescriptions were also recorded in a private prescription book, but these entries did not all include the date of prescribing and the date of dispensing. Controlled drugs registers were maintained, and balance reconciliations were made at the time of supply, with audits completed every two weeks and spot checks completed randomly. The maximum and minimum fridge temperatures and freezer temperatures were checked daily and monitored electronically.

Information governance training was mandatory for all staff and periodically repeated. Passwords to access the pharmacy IT systems were only known by authorised staff and individual passwords were

used to access the JAC system. Individual smart cards were used to access NHS summary care records and confidential material was suitably located and confidential paper waste was segregated and removed for safe disposal by the Trust. Safeguarding training was also mandatory for all staff and this was repeated annually. Pharmacists and technicians had all completed level 2 safeguarding while other pharmacy staff had completed level 1 safeguarding. Concerns were escalated through a central point according to the Trust's policy. Appropriate indemnity insurance was in place.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough staff to manage the workload. Team members have the appropriate qualifications for their roles and they complete regular ongoing learning so that they can keep their knowledge up to date. They work in an open culture and are able to raise concerns or provide feedback.

Inspector's evidence

There were enough suitably qualified and skilled staff present to manage the workload. In total, there were around 12 pharmacist, 6 technicians, 5 pre-registration pharmacists and 2 dispensary assistants. Some team members rotated between this site and other sites within the Trust and rotas were used to ensure continual cover. The Chief Pharmacist oversaw all sites and visited the pharmacy regularly, as did other pharmacist and technicians on the management team. There was a Dispensary Manager who supported the team on a day-to-day basis. All staff roles had a competency matrix which would clearly indicate the different processes staff could carry out. The staff were seen to be working well together during the inspection.

All staff had received or were undergoing accredited training and there was an induction process for new staff, with individual training programme for specific roles. The pre-registration pharmacists had regular training led by NHS Education and they would regularly attend study days off-site to learn more about the various clinical areas in preparation for the pre-registration exam. Pharmacists were supported to undertake clinical diplomas and CPD meetings were held regularly.

Staff received feedback during their appraisals which were held annually on a one-to-one basis with their line manager. The morning huddles were sometimes used to communicate current issues and team meetings were held to provide updates. The team described an open culture, where staff are able to contribute ideas or raise issues, and there was a Trust Whistleblowing policy. Some team targets were set relating to prescription processing times but these were not incentivised and patient safety remained the focus.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean, tidy and properly maintained. It provides a suitable space for the health services provided.

Inspector's evidence

The pharmacy included a reception area with dispensary to the rear, offices, a pharmacy store area and an aseptic suite. The pharmacy was bright, well-presented and fixtures and fittings were maintained. The work flow was organised, and there was an appropriate level of storage space. The pharmacy was clean, and the cleaning was completed daily by contracted cleaners. There wasn’t a dedicated pharmacy consultation room, but patients could be counselled in several discreet areas if required. Access to the pharmacy was controlled through key codes so only pharmacy staff could enter. The pharmacy store area was accessible to porters, but they could only enter if pharmacy team members were present. The pharmacy was locked when the department was closed, and out of hours access was only available to the on-call pharmacists who could enter if needed.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's services are accessible to people, and it manages them safely and effectively so that people receive appropriate care. It obtains medicines from licensed suppliers, and it carries out regular checks to make sure that they are in suitable condition to supply.

Inspector's evidence

The pharmacy was easy to locate and was accessible as it is located on the ground floor near to the main hospital reception. Patients could contact the pharmacy by phone and for patients not collecting prescriptions themselves, information was included in prescription bags with contact details of the pharmacy medicines helpline number. The registerable activity in the pharmacy included the supply of medicines on a named patient basis for a renal unit within the Trust and the dispensing of private prescriptions. The team would screen the prescriptions from the renal unit, which would then be dispensed, checked and then delivered to the renal unit.

There were clear working processes where work would be prioritised, tasks were allocated to different staff members. Medicines were labelled appropriately. Take home medication for private hospital patients was transported by nominated porters in suitable containers and patients would be counselled by appropriately trained staff when they received their medicines.The pharmacy team had an awareness of the strengthened warnings and measures to prevent valproate exposure during pregnancy. Valproate patient cards and leaflets were available for use during dispensing of valproates to all people in the at-risk group. The pharmacy team had access to blood test results for patients and would double check these when required for high risk medicines or any other appropriate medicines.

The pharmacy sourced stock from the main pharmacy store in Stoke Mandeville Hospital and received daily deliveries. Stock was received in the stores area and overseen by nominated staff. CDs were stored in a secure cabinets and CD keys were kept in a key safe and only accessible to nominated staff members. Fridge lines were mainly stored in a walk-in cold room; and aseptic fridge lines had their own dedicated fridge. There was also a freezer present for the storage of cold packs and a few medicines which required freezer storage. Temperatures were monitored, and alerts received if these were out of range so appropriate action could be taken. The pharmacy was registered with Secure Med, but they were not yet compliant with the European Falsified Medicines Directive (FMD). The Trust was working to implement a tailor-made FMD program to use in all their pharmacies and once this was operational, the team would start to use it.

The pharmacy held a waste contract and they tried to minimise waste by monitoring short dated stock, so it could be utilised before expiry where possible. Drug alerts and recalls were cascaded from the Stoke Mandeville site to the Dispensary Manager and delegated to a staff member to deal with. Action taken was taken as necessary and confirmation sent to the source. The recall notices were printed off, annotated to show the action taken and held in a file.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the appropriate equipment and facilities to provide its services safely. These are clean and fit for purpose.

Inspector's evidence

There were crown-stamped measures available for use and amber medicine bottles were seen to be capped when stored. There were also clean counting triangles available as well as capsule counters. Up to date reference sources were available such as a BNF, a BNF for Children, and a Drug Tariff as well as other pharmacy textbooks. Internet access was also available should the staff require further information sources.

The fridges and freezer were in good working order and the maximum and minimum temperatures were recorded daily and were seen to always be within the correct range. Designated bins for the disposal of waste medicines were available for use and the team also had bins for the disposal of hazardous waste medicines in the aseptic suite.

What do the summary findings for each principle mean?

Finding	Meaning
✔ Excellent practice	The pharmacy demonstrates innovation in the way it delivers pharmacy services which benefit the health needs of the local community, as well as performing well against the standards.
✔ Good practice	The pharmacy performs well against most of the standards and can demonstrate positive outcomes for patients from the way it delivers pharmacy services.
✔ Standards met	The pharmacy meets all the standards.
Standards not all met	The pharmacy has not met one or more standards.