General Pharmaceutical Council

# Registered pharmacy inspection report

**Pharmacy Name:** Pharmacy Department, Trafford General Hospital, Moorside Road, Davyhulme, MANCHESTER, Lancashire, M41 5SL

**Pharmacy reference:** 1033571

**Type of pharmacy:** Hospital

**Date of inspection:** 23/12/2019

## Pharmacy context

This pharmacy is situated within Trafford General Hospital, which is part of Manchester University NHS Foundation Trust (MFT). The vast majority of its workload relates to supplying medicines within the MFT. It is registered with the GPhC to enable it to supply NHS medication to people being treated for mental health conditions who are under the care of Greater Manchester Mental Health NHS Foundation Trust (GMMH).

## 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 | 2.1 | Good practice | Staff do not feel pressurised when working and complete tasks properly and effectively in advance of deadlines. And the pharmacy reviews its staffing levels so that they remain appropriate. |
| **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 generally manages its risks well. The pharmacy team follow written instructions to help make sure it provides safe services. The team records and reviews its mistakes so that it can learn from them. It keeps people's information secure. And the team understands its role in protecting and supporting vulnerable people.

### Inspector's evidence

The pharmacy had several written procedures for the safe dispensing of medicines, responsible pharmacist (RP) regulations and controlled drugs (CDs). Two committees within the hospital reviewed these procedures every two or three years. Staff signed a log at the end of each procedure to acknowledge their understanding of the procedures in place. Records indicated that all the staff had read and understood the procedures relevant to their role and responsibilities. However, some obsolete procedures were kept alongside the current version, which could lead to confusion about which procedure should be followed or whether they had been reviewed.

The dispenser and checker initialled dispensing labels, which helped to clarify who was responsible for each prescription medication supplied and assisted with investigating and managing mistakes. The pharmacy team recorded mistakes it identified when dispensing medicines and it addressed each of them separately. Team members participated in reviewing these records each month, so that they could reflect and identify any additional learning from them. The Pharmacy Learning from Incidents Group (PLIG), which included the pharmacy's operational managers, lead pharmacists and registered technicians who were clinical governance specialists also reviewed these records. The PLIG was also responsible for making sure actions to reduce the risk of a similar mistake were carried out.

The pharmacy's lead mental health pharmacist also investigated any incidents that occurred in relation to medications it had supplied, and the depth of each investigation depended on the seriousness of the incident. Records of each investigation were forwarded to any relevant parties, including the PLIG, senior pharmacy management, nurses and matrons. The PLIG also analysed the data from incident reports to identify any trends, and a medication safety briefing was subsequently issued to team members.

The team held a governance meeting around every six weeks, which reviewed the results of any departmental audit that had been conducted, and highlighted any clinical or information governance or safeguarding issues. It also included briefings on any medication safety updates, or changes to the pharmacy's risk register, for example in relation to staffing and medication security.

Publicly displayed information explained how people could make a complaint, and staff had read the pharmacy's procedure on handling complaints. People could also raise a complaint through the NHS Patient Advice and Liaison Service (PALS). GMMH had been advised to provide feedback or make a complaint via the lead mental health pharmacist. Staff said that the GMMH had made some positive comments on the few occasions that it had fed back. However, the pharmacy did not obtain structured feedback from GMMH about the quality of its service.

The pharmacy had professional indemnity cover for the services it provided. The RP prominently displayed their RP notice, so people could identify them. The pharmacy maintained the records

required by law for the RP and CD transactions. It did not supply any medication against private prescriptions, so a private prescription register was not required.

All the staff had completed the Trust's mandatory annual information governance training. The pharmacy regularly completed an information governance risk assessment, which helped to identify areas where protecting people's information needed to be addressed. Staff securely stored and destroyed written confidential material. People's prescriptions were stored and transported in sealed, discrete and opaque bags. Secure, designated bins were used to store confidential waste before an appropriate external waste contractor removed their contents and properly destroyed the information. It was unclear if GMMH had obtained people's consent to share their information with the pharmacy under the service level agreement. And the pharmacy did not obtain these people's explicit consent to access their information.

The pharmacists had level two safeguarding accreditation. And all the staff had completed the Trust's mandatory safeguarding training to at least a level one accreditation. The pharmacy had its Trust's safeguarding policy.

## Principle 2 - Staffing ✔ Standards met

### Summary findings

The pharmacy has enough staff to provide safe services and reviews its staffing levels so that it can respond to changes in workload. And the team members have the skills and experience needed for their roles. Each team member has a performance review and completes relevant training on time, so their skills and knowledge are up to date.

### Inspector's evidence

The operations manager, who was a registered pharmacy technician (technician) managed the pharmacy's services. The pharmacy divided its staff into four sub teams that covered dispensing, medicines procurement and storage, outsourcing of specials medicines and ward-based services. Four technicians each managed one of the sub teams, and reported to the operations manager. A band 8 pharmacist managed the pharmacist team. The dispensing team usually had the operations manager, three technicians and a dispenser on duty. The medicines procurement and storage team typically had the manager and four dispensers typically on duty. The outsourcing of specials medicines and ward-based services teams normally had a technician and the manager present throughout the working day.

The pharmacy had enough staff to comfortably manage its workload. It usually had prescription medicines ready in good time. The proportion of prescriptions from GMMH compared to the total number that the pharmacy received was low. So, the team did not usually experience any sustained pressure to supply medicines against these prescriptions.

The pharmacy had an effective strategy for covering planned and unplanned leave. The operations manager, sub team managers and lead pharmacists used a software system to manage how much leave each sub team could be allowed at any time, taking into consideration the band level of staff, skill mix and available pharmacists. Pharmacists and senior team members from MFT's two other pharmacies were available to cover unplanned leave at short notice. MFT also reviewed the amount of unplanned leave the team had taken, how much external staffing cover the pharmacy used and planning for it.

MFT's senior leadership committee kept all its pharmacys' staffing arrangements under review. All three of MFT's pharmacies worked closely with each other operationally on a regular basis, which helped to advance a more flexible strategy for developing the team members. Pharmacists and senior team members interchanged between working at all three pharmacies, which supported the sharing of best practice and made it easier for staff to transition between pharmacies.

After one year's employment with MFT band 6 pharmacists were enrolled on a clinical diploma, and two pharmacists were training to become non-medical prescribers. The pharmacy planned for all its band 4 dispensers to become accuracy checkers. Senior staff and managers had access to courses on leadership, communication, time management, conducting interviews and appraisal training. All team members had completed the pharmacy's mandatory training programme, which the operations manager monitored for compliance. New staff had a six-month probation and reviewed their performance with their manager at two weeks, and two, five and six months. And trainee dispensers were enrolled on an NVQ level two dispensing accreditation course. Staff could also access additional training, and they had protected study time. The team did not receive much training on medicines for treating mental health conditions that was relevant to the registrable activity. Very few of the team were trained in dispensing clozapine, and more detailed mental health training was not in place for new

staff entering at band level four. The Trust was reviewing the pharmacy's education and training strategy as part of a wider evaluation across all three of its pharmacies.

All the team members had a regular performance review, during which they agreed their objectives and reviewed them monthly with their line manager. And MFT monitored how well staff participated in the process. Team members whose performance needed significant improvement were given additional support. They completed their own personal reflection record of any mistakes they had made. If they were involved in a series of mistakes the team member would have discussions with a senior member of the team to identify any patterns and other learning and their performance would be more closely managed.

The pharmacy had an effective recruitment strategy. It recently reviewed its staffing profile, which led to the committee creating a vacancy for a procurement and storage team member. The pharmacy, which had a low staff turnover rate, recently recruited a band four dispenser who would join the dispensing team. And it filled vacancies usually within three months, partly because it retained staff from previous recruitment rounds on a reserve list for any future roles that it created.

A significant proportion of the staff had participated in a departmental survey that would be published in early 2020, which they completed anonymously. MFT also had a whistleblowing policy which allowed team members to raised concerns in anonymity.

The pharmacy had targets for reviewing people's prescribed medicines within twenty-four, forty-eight and seventy-two hours of being admitted to hospital. Senior management and pharmacists said these targets were realistic and achievable as the pharmacy had usually assessed all these people within forty-eight hours of their admission. The pharmacy also had a target for issuing people's discharge information to their GP within twenty-four hours after they were released from hospital. Staff said that they achieved the target virtually all the time because they collaborated well with the ward clerks and doctors. The Trust management generally understood that the reasons why on the rare occasions the pharmacy missed the target were beyond its control. For example, a new set of Junior doctors had started their training, so needed time to adjust.

## Principle 3 - Premises ✔ Standards met

### Summary findings

The premises are clean, secure and spacious enough for the pharmacy’s services. It has a private consultation area, so members of the public can have confidential conversations and maintain their privacy.

### Inspector's evidence

The pharmacy was situated in a purpose-built unit within the hospital and it was professional in appearance. The dispensary waiting and storage areas were appropriately maintained and to suitable standard of a hygiene. The waiting area could accommodate the number of people who usually presented at any one time and several chairs were available for people to use. A senior pharmacist said that the premises was subject to regular health and safety risk assessments, which included fire safety.

The open-plan dispensary provided enough space for the volume and nature of the pharmacy's services. The pharmacy dispensed a limited number of prescriptions that GMMH had issued for out-patients. Although there was no designated consultation room where these patients could have a private conversation, a senior pharmacist said that any confidential discussions with people would take place in a private area of the pharmacy that unauthorised persons could not access alone.

The public entrance to the premises were secured when the pharmacy was closed, an intruder alarm was installed, and the hospital security were on-site continuously. Access to the dispensary and the pharmacy’s offices always remained secure and only the pharmacy staff could gain entry to these areas.

## Principle 4 - Services ✔ Standards met

### Summary findings

The pharmacy's working practices are suitably effective, which helps make sure people receive safe services. It gets its medicines from licensed suppliers and manages them effectively to make sure they are in good condition and suitable to supply.

### Inspector's evidence

The pharmacy was open Monday to Friday 9am to 5pm and Saturday 9am-12pm and bank holidays 10am to 1pm. It had a step-free entrance and staff could see anyone needing assistance and support entering the premises. Most of the people receiving the pharmacy's mental health services were in-patients, and the hospital's porters or nurses usually directly delivered their medication to their ward.

The pharmacy supplied a range of medicines against prescriptions for treating mental health conditions, a significant number of which included clozapine. It followed several measures help to make sure clozapine was dispensed safely and at a beneficial dose. It had written procedures for dispensing clozapine. However, these procedures were last reviewed in 2014, so the team may not be following the latest best practice. Only team members who had specific clozapine training were authorised to dispense clozapine. A technician, who was a mental health specialist, attended the weekly clozapine clinic where they checked the MFT's electronic database to make sure people had a blood test result that validated further clozapine supplies, identified any people who were due a blood test, needed a new prescription or their dose changed, and they took appropriate action. The authorised team members also monitored the neutrophil count and any side effects for people taking clozapine. The pharmacy also followed the MFT's clozapine guidelines, which stated to issue the medicine when the scheduled blood test was overdue, but the last result remained valid. So, the pharmacy avoided people being without their medicine. Prescriptions were issued either weekly, fortnight or monthly, depending on the level of support people needed. And the pharmacy only supplied one specific clozapine product, which helped to maintain the therapeutic benefits and reduce the risk of side-effects. Prepared supplies of clozapine were stored in a separate designated area of the pharmacy along with people's clozapine monitoring sheets, which were needed for reference.

The pharmacy was part of wider care team for people taking clozapine, which included a physical and mental health nurse, a community shared-care nurse, and healthcare assistants who provided the phlebotomy service. So, team members collaborated with other healthcare professionals who shared in these people's care.

The team effectively dealt with urgent care situations when clinicians at other local Trusts had suddenly stopped people's clozapine without any clear reason, which could cause significant complications. It usually arranged resumption of clozapine prescribing before people experienced any withdrawal symptoms. Nevertheless, the pharmacy could have communicated more proactively with other hospital pharmacies to reduce the risk of people being without their clozapine.

Staff said that the pharmacy had written procedures for dispensing valproate, which the pharmacists developed in conjuction with GMMH. However, they could not locate these procedures. The pharmacy had very few people prescribed valproate, and it did not dispense the medication to anyone in the at-risk group unless they had a semi-permanent form of contraception such as an intra-uterine device, depot injection or an implant. Staff also said that the pharmacy had written procedures for dispensing

other higher-risk medicines that covered, lithium, warfarin and methotrexate.

The pharmacy obtained its medicines from a range of licensed pharmaceutical wholesalers and stored them in an organised manner. However, the pharmacy did not yet have a system for complying with the Falsified Medicines Directive (FMD), as required by law.

Most of the stock medication was stored inside an automated dispensing robot, located within the pharmacy, and most of these were assigned a standard six-month shelf life on an electronic monitoring system. Individual medicines could also be given their own specific shelf life. Each month the robot removed any stock reaching the end of its shelf life, and staff manually checked these expiry dates. They quarantined any of these medications that were due to expire, and any that still had a reasonably long expiry date were returned to the robot with a further three months shelf life.

Staff explained that the medicines stored on the dispensary shelves had their expiry dates checked every six months, and corresponding records confirmed this routine. However, as the team realised that medication could expire between these checks, they would be increasing the checks to every month. Any medications due to expire within three months were highlighted to identify them as short-dated. A number of liquid medicines had the date on which they were opened written on their bottle, which helped make sure they were not used after their appropriate expiration date.

Staff monitored the refrigerated medication storage temperatures. The pharmacy's procurement team took appropriate action when it received alerts for medicines suspected of not being fit for purpose and recorded the action that it had taken. It disposed of obsolete medicines in waste bins kept away from medicines stock, and it had documents advising on the appropriate disposal of hazardous waste. This reduced the risk of any unfit products becoming mixed with stock or supplying medicines that might be unsuitable. Records indicated that medicines were supplied to wards securely.

## Principle 5 - Equipment and facilities ✔ Standards met

### Summary findings

The pharmacy has the equipment that it needs to provide its services effectively. It suitably stores and maintains the equipment, and it has the facilities to secure people's information.

### Inspector's evidence

The pharmacy team kept the dispensary sink clean, and it was only used for medicines preparation. It had hot and cold running water. Staff had access to WC facilities in the pharmacy and within the hospital, which each had appropriate hand washing facilities. The team had a range of clean measures, so it had the facilities to make sure it did not contaminate the medicines it handled and could accurately measure and give people their prescribed volume of medicine. The thermometers for the medication refrigerators were calibrated every two years. A maintenance contract was in place for the dispensing robot, and staff could contact the robot manufacturer's technical support help line if needed. Staff could also manually override and enter the robot in the event of it breaking down, so that services could be maintained.

The pharmacy team had access to a range of pharmaceutical information resources, including the BNF and cBNF, and it had an electronic subscription to Medicines Complete and Stockley's drug interactions. The pharmacy also had access to the hospital's medicines information service.

People's medical records were stored on password protected electronic systems. Computer screens were all positioned out of public view, which helped to keep people's information confidential. Cordless phones were available to enable conversations to take place in private. Staff also needed an authorised card to access people's information when they were on a ward.

## 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. |