General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: LANCASHIRE HOSPITALS SERVICES (PHARMACY) LTD, Royal Preston Hospital, Sharoe Green Lane, PRESTON, Lancashire, PR2 9HT

Pharmacy reference: 1033854

Type of pharmacy: Hospital

Date of inspection: 06/01/2020

Pharmacy context

This is a pharmacy situated in the main hospital entrance of Royal Preston Hospital, in Lancashire. It is contracted by Lancashire Teaching Hospitals NHS Foundation Trust to dispense prescriptions issued by its outpatient services and emergency department. It does not sell any over-the-counter medicines or provide any other services.

Overall inspection outcome

Standards not all met

Required Action: Improvement Action Plan

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 not all met	2.4	Standard not met	Members of the pharmacy team do not feel well supported and this has created a stressful environment which reduces their effectiveness.
		2.5	Standard not met	Staff believe concerns they raise are ignored by senior management.
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 team follows written procedures, and this helps to maintain the safety and effectiveness of the pharmacy's services. The pharmacy keeps the records it needs to by law. And members of the team are given training so that they know how to keep private information safe. But they do not always make records of things that go wrong. So they may miss opportunities to learn from them and prevent the same mistakes happening again.

Inspector's evidence

There was a current set of standard operating procedures (SOPs) which were issued in September 2018 and their stated date of review was September 2020. Members of the pharmacy team had signed to say they had read and accepted the SOPs. But the SOPs did not cover the arrangements to apply during the absence of the responsible pharmacist (RP) from the premises. So members of the pharmacy team may not always know what to do in these circumstances.

The pharmacist said any dispensing errors that were reported by an NHS employee were electronically recorded on the hospital's 'Datix' recording system. If the error had been reported by a member of the public, the pharmacist said he would record the error on a standardised 'reflective summary' form. The last recorded error was in July 2019, and members of the pharmacy team said they did not think all errors had been recorded. The operations manager said that the staff were mistaken about the process, and all errors should be recorded on the Datix system. He said some errors had been recorded on an electronic form, but these records were not seen. He said he would retrain the pharmacy team on the SOP to remind them of the correct procedure. A paper log was available to record near miss incidents. But few had been recorded, and the pharmacy team confirmed some incidents had not been documented. The pharmacist explained that he would highlight mistakes to staff at the point of accuracy check and ask them to rectify their own errors. Members of the pharmacy team provided examples of action which had been taken to help prevent similar mistakes. For example, segregating trimethoprim 100mg and 200mg tablets to help avoid picking errors.

Roles and responsibilities of the pharmacy team were described in individual SOPs. A locum pharmacy technician was able to explain what her responsibilities were and was clear about the tasks which could or could not be conducted during the absence of a pharmacist. Staff wore standard uniforms and had badges identifying their names and roles. The RP had their notice displayed prominently. The pharmacy had a complaints procedure. A notice was on display and it advised people they could discuss any concerns or feedback with the pharmacy team. Any complaints would be recorded to be followed up by the management team. A current certificate of professional indemnity insurance was seen.

Records for the RP and unlicensed specials appeared to be in order. Controlled drugs (CDs) registers were maintained with running balances recorded and checked weekly. Two balances were checked, and both were found to be accurate.

An information governance (IG) policy was available. The pharmacy team had been given in-house training and each member had signed a confidentiality agreement. When questioned, a dispenser was able to describe how confidential waste was destroyed on-site using a shredder. There was no privacy notice on display. So people may not always be fully informed about how the pharmacy handles their information.

Safeguarding procedures were available and included the contact details of the hospital's safeguarding leads. The pharmacy team had in-house training and the pharmacist said he had completed level 2 safeguarding training. A dispenser said she would initially report any concerns to the pharmacist on duty.

Principle 2 - Staffing **Standards not all met**

Summary findings

There are usually enough staff to manage the pharmacy's workload. But there is a lack of leadership and staff do not feel well supported. There is a high turnover of staff and a reliance on temporary staff, which causes friction within the team. And this means the pharmacy team works less effectively. Members of the team can raise concerns, but they do not feel they are listened to or that their concerns are addressed.

Inspector's evidence

The pharmacy team included two pharmacists – one of whom was the superintendent, four pharmacy technicians – two of whom were trained to accuracy check (ACT), two dispensers and two reception counter staff. The pharmacy had been without a pharmacy manager for 6 months. A locum pharmacy technician was contracted to work full time as part of the team.

Until 2pm each day, the normal staffing level was one to two pharmacists, two ACTs, and four staff. After 2pm, there was a pharmacist, an ACT and one or two dispensers. There was a reliance upon agency staff to help maintain the staffing level. And members of the pharmacy team were regularly asked to work elsewhere at one of the two other pharmacies owned by the company. There was a high footfall into the pharmacy, and members of the team said they could not always keep up to date with some routine tasks, such as date checking and recording errors.

All members of the pharmacy team had completed appropriate training for their roles. But they did not receive any ongoing training to help them keep their knowledge up to date. Members of the team said they had been invited to attend training sessions with hospital staff but did not have enough time to participate.

A pharmacy technician said she was able to question a prescription if she felt it was necessary. She provided an example of where a dose for an antibiotic was missing which required confirmation from the prescriber. A locum pharmacist said she felt able to exercise her professional judgement and her decisions were respected by the rest of the pharmacy team. A dispenser who had commenced their employment around 6 months ago said she felt a good level of support from the pharmacy team, and she felt able to ask for further help if she needed it. But other members of the team raised concerns about the lack of support during the absence of a manager. They explained that there had been a high turnover of staff in the previous 4 to 5 months. And said changes to the team and reliance on temporary staff meant members of the team were often not familiar with how the pharmacy operated. This created a stressful environment and meant they worked less effectively. Five members of the team said they had raised concerns about problems to senior management. But the response they received back did not appear to address or acknowledge the issues they raised.

Appraisals were conducted annually by the company. A dispenser said she felt the appraisal process was a good chance to receive feedback about her work. There were numerous targets, such as the waiting time for a prescription to be dispensed. A locum pharmacist said she did not feel under pressure to achieve these.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are suitable for the services provided. There are some facilities to enable a private conversation.

Inspector's evidence

The pharmacy was clean and tidy, and appeared adequately maintained. The size of the dispensary was sufficient for the workload. A sink was available within the dispensary. A lockable door prevented access to the dispensary, and people were not able to view any patient sensitive information. The pharmacy did not have a consultation room, but the counter area was screened so that patients could be counselled without the conversation being overheard. There was also a private corridor which could be used if necessary. The temperature was controlled by the use of air conditioning units. Lighting was sufficient. The staff had access to a kitchenette and on-site WC facilities.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's services are easy to access. And it manages and provides them safely. It gets its medicines from recognised sources, stores them appropriately and carries out some checks to help make sure that they are in good condition.

Inspector's evidence

Access to the pharmacy was level via the hospital’s main entrance and it was suitable for wheelchair users. A poster gave information about the services offered and the hours of opening.

The sole function of the pharmacy was to dispense outpatient prescriptions for Lancashire Teaching Hospitals NHS Foundation Trust. Prescriptions could only be dispensed at one of Lancashire Hospital Services (Pharmacy) Ltd pharmacies in Preston Royal Hospital, Rosemere Cancer Centre, or Chorley and South Ribble Hospital. When people handed in their prescription to the pharmacy, a member of the team would confirm the patient's details. Such as their name, address and any known drug allergies. Prescriptions were placed into different coloured trays to help manage the workflow.

The dispenser would mark the prescription with their initials and the quantity supplied to provide an audit trail. There was a box for the pharmacist to mark following a clinical check of the prescription. Once this had been completed, an accuracy checker could perform the final accuracy check. The pharmacist had access to the hospital’s blood test database and this could be used if there was a query about the dosage of the medication. Information leaflets were provided to patients to provide counselling about the medication they were taking.

Dispensed medicines awaiting collection were kept on a collection shelf using an alphabetical retrieval system. Prescription forms were retained, and stickers were used to clearly identify when fridge or CD safe storage items needed to be added. Staff were seen to confirm the patient’s name and address when medicines were handed out. If a member of NHS staff collected the medicines on behalf of the patient, they were required to show their ID badge and sign a collection sheet. The pharmacy had a delivery service. Deliveries were segregated after their accuracy check and a member of the pharmacy team would contact the patient to arrange a delivery date. A delivery sheet was used to obtain signatures from the recipient to confirm delivery.

The staff were aware of the risks associated with the use of valproate during pregnancy. Educational material was available to hand out when the medicines were supplied. The pharmacist said he would speak to any patients who were at risk to make sure they were aware of the pregnancy prevention programme.

Medicines were obtained from licensed wholesalers, and any unlicensed medicines were sourced from a specials manufacturer. The pharmacy was not yet meeting the safety features of the falsified medicine directive (FMD), which is now a legal requirement. The hospital was waiting for their PMR software and equipment to be updated by their supplier. The expiry dates of stock were usually checked every 3 months. A date checking matrix was on the wall, but it had not been signed by staff since June 2019. The pharmacy team said some date checking had been completed but it was not recorded, and they were behind with the schedule. Shelving was cleaned as part of the process and short dated stock was highlighted using a sticker. Liquid medication had the date of opening written on.

A random spot check of the dispensary stock did not find any out of date medicines.

Controlled drugs were stored appropriately in the CD cabinets, with clear segregation between current stock, patient returns and out of date stock. CD denaturing kits were available for use. There was a clean medicines fridge with a thermometer. The minimum and maximum temperature was being recorded daily and records showed they had been within the required range. Patient returned medication was disposed of in designated bins. Drug alerts were received by email from the MHRA. Alerts were printed, action taken was written on, initialled and signed before being filed in a folder.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

Members of the pharmacy team have access to the equipment they need for the services they provide. And they maintain the equipment so that it is safe to use.

Inspector's evidence

The staff had access to the internet for general information. This included access to the BNF, BNFc and drug tariff resources. All electrical equipment appeared to be in working order. According to the stickers attached, electrical equipment had last been PAT tested in September 2018. There was a selection of liquid measures with British Standard and Crown marks. The pharmacy also had equipment for counting loose tablets and capsules, including tablet triangles, a capsule counter and a designated tablet triangle for cytotoxic medication. Equipment was kept clean.

Computers were password protected and screens were positioned so that they weren't visible from the public areas of the pharmacy. A cordless phone was available in the pharmacy which allowed the staff to move to a private area if the phone call warranted privacy.

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.