

Registered pharmacy inspection report

Pharmacy Name: Pharmacy Department, Harrogate District Hospital,
Fewston Wing, Lancaster Park Road, HARROGATE, North Yorkshire,
HG2 7SX

Pharmacy reference: 1079033

Type of pharmacy: Hospital

Date of inspection: 20/03/2024

Pharmacy context

The pharmacy is inside Harrogate District Hospital. It supplies medicines for people in the hospital. It is registered with GPhC to occasionally dispense emergency NHS prescriptions originating from primary care. This constitutes a very small proportion of the pharmacy's overall dispensing activities.

Overall inspection outcome

✓ **Standards met**

Required Action: None

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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	2.5	Good practice	Pharmacy team members are actively encouraged and empowered to suggest and implement improvements to the quality of the pharmacy's services.
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 effectively identifies and manages risks with its services. Pharmacy team members understand their role in protecting vulnerable people. And they suitably protect people's confidential information. They record and discuss the mistakes they make so that they can learn from them, and they share their learning publicly. But they don't always capture key information about causes of errors, so they may miss some opportunities to learn and improve.

Inspector's evidence

The pharmacy was in the main hospital building of Harrogate District Hospital. It was registered with GPhC to dispense NHS prescriptions originating from primary care. The superintendent pharmacist (SI) explained that this happened occasionally. People usually brought these prescriptions to the hospital in an emergency when they were unable to obtain their medicines in a community pharmacy.

The pharmacy had a set of standard operating procedures (SOPs) to help pharmacy team members manage risks. These were reviewed every two to three years or when there was a significant event that prompted a review of a procedure. Updated SOPs were emailed to all relevant staff to read, and team members discussed their understanding of updated SOPs with their line manager at regular monthly meetings. Team members signed to confirm they had read and understood the SOPs during their initial induction when they started their role. But the pharmacy did not have a process to capture team members' understanding after they had read updated and amended SOPs.

Pharmacy team members highlighted and recorded errors identified before people received their medicines, known as near miss errors. And they recorded and learnt from dispensing errors, which were errors identified after the person had received their medicines. There were documented procedures to help them do this effectively. They discussed their errors and why they might have happened. And they used this information to make some changes to help prevent the same or similar mistakes from happening again. Following a recent improvement audit, the pharmacy had changed the way team members recorded their errors to help encourage a more open learning culture. Since the change, the pharmacy had seen an increase in the number of near miss errors being recorded. Team members did not always capture information about why the mistakes had been made to help aid analysis and learning. The pharmacy had a process for analysing the information collected about errors. The lead technician for medicines optimisation analysed the data each month. They recorded their findings and discussed them with the team at monthly briefings. Team members were asked to suggest ways to reduce the risks of the patterns occurring and their suggestions were implemented. The pharmacy had a clear process for managing a dispensing error. Each error was allocated to the most appropriate senior manager to handle. The manager led the analysis of the error and managed the implementation of the necessary learning and changes required to help prevent a recurrence. This would often include liaising with colleagues who worked elsewhere in the hospital, depending on the scope of the error.

The pharmacy displayed a quality and care board in the foyer where people waited for the prescriptions. Team members updated the board each month after their medicines optimisation briefing. The board displayed information about errors made the previous month, the key risks identified and the key messages and learning the team had taken from the data to help improve their

services and manage the risks identified. The pharmacy also produced a medicines management briefing every quarter which was sent to people across the organisation. The bulletin identified trend from errors involving medicines from across the hospital, so team members could learn and make necessary changes to improve safety. A recent example had highlighted frequent mistakes involving inappropriate dosing of insulin when people were changed from one type of insulin to another.

The pharmacy had a documented procedure for handling complaints from people. Pharmacy team members explained people usually provided verbal feedback. And they shared examples of complimentary feedback they had received to celebrate the team's successes. The pharmacy did not have a formal process in place to collect feedback about its services. And there was no information available for people in the public waiting area about how to provide the pharmacy with feedback.

The pharmacy had current professional indemnity insurance. It kept accurate controlled drug (CD) registers electronically, with running balances in all registers. Pharmacy team members audited these registers against the physical stock quantity every time they dispensed a CD, and on a daily rolling cycle. This meant all CDs were audited at least once a week. The pharmacy maintained a responsible pharmacist record, which was also up to date. The pharmacist displayed their responsible pharmacist notice so they could be identified. Pharmacy team members electronically monitored and recorded fridge temperatures daily in several fridges and cold storage areas. The pharmacy did not dispense private prescriptions or emergency supplies.

The pharmacy kept sensitive information and materials in restricted areas. It collected confidential waste in dedicated bins, which were emptied periodically, and the contents taken for secure destruction. The pharmacy had a documented procedure in place to help pharmacy team members manage people's sensitive information. Team members explained how important it was to protect people's privacy and how they would protect confidentiality. And they completed mandatory training on this each year. A pharmacy team member gave some examples of signs that would raise their concerns about the welfare of vulnerable children and adults. And how they would refer to their manager and the hospital's safeguarding manager. The pharmacy had procedures for dealing with safeguarding concerns. Pharmacy team members completed mandatory safeguarding training every year.

Principle 2 - Staffing ✓ Standards met

Summary findings

The pharmacy's team members are suitably qualified for their roles and the services they provide. They confidently discuss their learning and development needs together. And they are good at supporting each other to make effective changes to improve the quality of the services they provide. Team members complete ongoing training to keep their knowledge and skills up to date. They manage the workload well and feel comfortable raising and discussing concerns.

Inspector's evidence

All pharmacy team members who handled medicines were trained to at least dispenser level. The pharmacy also employed several pharmacy technicians, some of whom were accredited and competent to perform the final accuracy checks of prescriptions. Team members were required to complete a competency log as part of their induction training to assess their competence to be able to work with different types of prescriptions. This included general dispensing, preparing CD prescriptions, and prescriptions for other higher risk medicines. Team members completed mandatory e-learning modules regularly, which covered mandatory compliance training such as information governance and safeguarding set by the hospital trust. And more clinical topics set by the pharmacy, such as sepsis and dementia awareness.

Pharmacy team members took part in a hospital-wide quality improvement (QI) programme. They were able to achieve bronze, silver, and gold QI awards. And the pharmacy actively encouraged team members to put forward ideas about how to improve safety and quality of services, even when they were not striving for a QI award. Each level of the award was accompanied by a two-day training course to teach team members about risk and how to influence quality improvement. A trainee pharmacy technician explained a recent example, where they had identified trends in errors being made involving insulin. And these errors were occurring in the pharmacy and on hospital wards. They carried out an audit of these errors to help inform the scale of the issue and the causes of the errors being made. And they identified the need to improve how insulin was stored and to improve people's knowledge of the different types of insulin available. They designed and implemented a system to label insulin more clearly on the fridge shelves in the pharmacy. The system helped team members to better understand which type of insulin they required. And to clearly highlight the risks of each different strength and type of insulin, to help them select the correct product when dispensing. They completed a further audit shortly after the system had been implemented. And their data showed a marked reduction in errors involving insulin. The success of the system was shared across the hospital, and this resulted in the system also being implemented on hospital wards to help reduce the risks of selection and administration errors involving insulin.

The pharmacy had an appraisal process for pharmacy team members. They had a meeting every year with their manager to discuss their performance, who set objectives to address any learning needs identified. One example of an objective set was a team member identifying their lack of knowledge working in different areas of the pharmacy besides their own specialist area. So, the team provided them with more opportunities to shadow and help more experienced colleagues to help improve their knowledge and confidence in other areas. Team members also had a one-to-one meeting with their manager each month to discuss their progress. But they explained these meetings were also more holistic and helped to determine their general wellbeing, rather than only assessing their performance.

Team members explained how they would raise professional concerns with their manager or head of department. They felt comfortable raising concerns and making suggestions to help improve the pharmacy's ways of working. They were confident that their concerns and suggestions would be considered, and changes made where they were needed. And they were provided with regular opportunities to communicate and implement their ideas and feedback. The pharmacy had a whistleblowing policy, but pharmacy team members were unsure about how to access the procedure. The team communicated openly and worked well together during the inspection.

Principle 3 - Premises ✓ Standards met

Summary findings

The pharmacy is clean, secure, and properly maintained. It provides a suitable space for the services it provides.

Inspector's evidence

The pharmacy was clean and well maintained. And the benches where medicines were prepared were tidy and well organised. The pharmacy's floors and passageways were free from clutter and obstruction. The pharmacy kept equipment and stock on shelves throughout the premises. And some medicines were stored in a robotic dispensing system. The pharmacy did not have a consultation room for team members to use to have private conversations with people. The SI explained that the pharmacy's waiting area was rarely busy, and team members were usually able to have private conversations with people in the waiting area. Team members were aware of the need to protect people privacy and explained how they would manage confidentiality if there was more than one person waiting for prescriptions.

There was a clean, well-maintained sink in the dispensary used for medicines preparation. There was a toilet with a sink which provided hot and cold running water and other facilities for hand washing. The pharmacy kept heating and lighting to acceptable levels.

Principle 4 - Services ✓ Standards met

Summary findings

Pharmacy team members manage and provide the pharmacy's services safely and effectively. The pharmacy suitably sources its medicines. And it stores and manages its medicines appropriately. The pharmacy's services are easy for people to access. And it uses technology well to help reduce risks in the dispensing process.

Inspector's evidence

The pharmacy had level access from the hospital corridor. Team members explained how they would communicate in writing with people with a hearing impairment. They could provide large-print labels and instruction sheets to help people with a visual impairment access the pharmacy's services. Team members were also able to access a telephone translation service to help communicate with people who did not speak English. The pharmacy displayed a poster in the waiting area showing key members of the pharmacy team, their roles, and responsibilities, to help people understand who was helping them and to demonstrate their prescription's journey. Team members also used other areas in the waiting area to display various information. These topics changed regularly, often in line with health promotion campaigns and priorities. Some examples included smoking cessation and winter health.

The pharmacy used robotic technology in the dispensing process to help speed up the process and reduce the risk of selection errors. Some medicines were unable to be stored in the robot, so the pharmacy stored these items tidily on shelves and in drawers in various places around the pharmacy. Pharmacy team members who worked to stock and maintain the robot had individual login to access the system. The process for ejecting medicine packs from the robot on a monthly basis, as part of the date checking process, meant that short-dated items with less than six months expiry were removed from the robot. Team members recorded regular checks of medicine expiry dates elsewhere in the pharmacy. They completed checks on a rolling cycle. They highlighted and recorded any short-dated items up to six months before their expiry. And they removed expiring items during the check before they were due to expire.

Pharmacy team members signed the 'dispensed by' and 'checked by' boxes on dispensing labels during dispensing. And each prescription contained a record of all team members that had been involved with the prescribing and dispensing the medicines. This was to maintain an audit trail of the people involved in the prescribing and dispensing process. They used baskets throughout the dispensing process to help prevent prescriptions being mixed up. The final accuracy of some prescriptions was checked by accuracy checking technicians (ACTs). Prescriptions clearly displayed whether they had been clinically checked by a pharmacist. And ACT were clear about the circumstances that meant they could not check a prescription. The pharmacy had a policy to help them do this safely and effectively.

The pharmacy used an electronic system that monitored and recorded the temperatures in the pharmacy's fridges constantly. If a fridge was outside of expected ranges, team members were alerted by an alarm. And there was a policy in place to help team members quickly manage the situation and minimise the risks of medicines being wasted. If a fridge temperature went out of range when the pharmacy was closed, the system alerted the on-call pharmacist who would respond and manage the situation. Pharmacy team members responded to medicine recalls they received from manufacturers and other agencies. This was managed by the pharmacy's procurement team. They removed any

affected medicines from the shelves in the pharmacy, and if necessary, they removed affected medicines from ward stock as well. They recorded the actions they had taken. The pharmacy obtained medicines from licensed wholesalers via a regional procurement system. New wholesalers were subjected to due diligence checks to confirm they were cost-effective and legitimate before orders were placed. The pharmacy had disposal facilities available for unwanted medicines, including CDs.

Principle 5 - Equipment and facilities ✓ Standards met

Summary findings

The pharmacy has the equipment it needs to provide its services safely. It maintains its equipment properly, so it is safe to use. And it has access to prompt technical support in an emergency. Pharmacy team members manage and use the equipment in ways that protect people's confidentiality.

Inspector's evidence

The pharmacy had the equipment it needed to provide the services offered. It had reference resources available, including the British National Formulary (BNF), the BNF for Children, various pharmacy reference texts and use of the internet. The pharmacy could also access the medicines information services at a neighbouring NHS trust that provided advice and support about more complex medicines queries. The pharmacy had a set of clean, well-maintained measures available for liquid medicines preparation.

The pharmacy had suitable containers available to collect and segregate its confidential waste. It kept its password-protected computer terminals in the secure areas of the pharmacy, away from public view and where people's private information was protected. The pharmacy had a maintenance contract to help support them if issues occurred with their robotic and electronic dispensing systems. They were able to access telephone support 24 hours a day. And on-site support from an engineer was available within four hours if an issue could not be resolved remotely.

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.