General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: London North West Healthcare NHS Trust,

Pharmacy Department, Northwick Park Hospital, Watford Road, HARROW, Middlesex, HA1 3UJ

Pharmacy reference: 1102146

Type of pharmacy: Hospital

Date of inspection: 25/09/2019

Pharmacy context

This is a pharmacy in Northwick Park Hospital in Harrow, London, which provides pharmacy services for patients receiving treatment at the hospital. 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 activity relevant to this report is the supply of prescription medicines to patients undergoing dialysis at a satellite renal unit run by Imperial College Healthcare, on the same site.

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	1.1	Good practice	The pharmacy keeps an up-to-date risk register which is reviewed every month.
		1.2	Good practice	Staff members learn from incidents and make changes to their practice to prevent them from happening again.
2. Staff	Standards met	2.1	Good practice	The staff rota in the pharmacy ensures there is always a mix in the skills of staff at all times in the pharmacy.
		2.2	Good practice	Members of staff complete regular training and progression schemes have been introduced to retain staff members.
		2.4	Good practice	The pharmacy team members are able to use their own judgement and contribute ideas to improve service delivery.
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 read through these and 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 pharmacy. The team also had SOPs for the rest of the pharmacy tasks which all included the roles and responsibilities of the staff. Appropriate professional indemnity insurance was in place.

The pharmacy had a risk register in place which was updated every month and reviewed within the Divisional Clinical Governance meetings and in the three-monthly Trust wide Dispensary Quality Management Review Meetings. All 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 regularly 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. The team held a file of near misses and errors of significance which included images of the mistake as well as a summary of why the incident occurred and the following action. This file would be provided to all new members of staff to look through and would also be held as a reference source. The team had an error whereby they had accidentally handed out one patient's medicine to another patient as they had the same ticket number. They explained that they have a ticketing number from 0 to 9,999 and can dispense this amount in a month so one patient had not collected their medicines and the medicines for the patient of the previous month had been handed out. As a result of this incident, one of the technicians in the pharmacy suggested that the tickets should have a different colour every month to prevent a similar incident recurring. The pharmacy implemented this suggestion and the team explained that it had been working.

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 related to 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. 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. Controlled drugs registers were maintained, and balance reconciliations were made at the time of supply, with audits completed every three months and spot checks completed randomly. Stock checks, generated by the stock control system, are undertaken on a rolling basis. 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. Individual NHS smart cards were used, 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. The 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 and the chief nurse in the hospital was the safeguarding lead.

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 240 members of the pharmacy team across the Trust and 150 at Northwick Park Hospital, with around 71 whole time equivalent pharmacists, 28 of whom were independent prescribing pharmacists, 41 whole equivalent technicians and the rest being pharmacy assistants and administration staff. Some team members rotated between this site and other sites within the Trust and rotas were used to ensure continual cover and a mix of senior, junior and student members of staff at all times. The Chief Pharmacist oversaw all sites and visited the pharmacies regularly. All sections work together with their cross site counterparts and Band 6 and Band 7 pharmacists rotate between sites. There was a Dispensary Manager who supported the team on a day-to-day basis.

All the SOPs define the staff group who may work under the SOP and members of staff complete a training pack on induction tailored to the role, including competency logs. 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 the team had implemented a progression scheme for band 4 technicians to retain staff and make them feel more valued.

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 were able to contribute ideas or raise issues, and there was a Trust Whistleblowing policy. Team members were able to work within their own professional judgement which was emphasised during the induction and in Team Talks. There are no financial incentives within the Trust with the focus being solely on patient care.

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 was located on the ground floor of the hospital and included a large dispensary with reception area, ancillary rooms and offices. The pharmacy stores were located on the floor directly below the department and there was a separate aseptic and manufacturing suite. The dispensary fixtures and fittings were older, but well maintained and the pharmacy was bright and well-presented. The work flow was organised, and some non-urgent work was sent to Central Middlesex Hospital to be completed due to a lack of space onsite. There are plans in place to move all medicines used in aseptic dispensing to another location to allow the pharmacy to introduce a robot to improve efficiency. In addition, there are plans to have a Wholly Owned Subsidiary which will provide the outpatient service for the site.

Contract cleaners were used to clean the pharmacy and additional cleaning could be requested when required. The premises were checked by the dispensary manager and cleaning supervisor, and cleaning logs reviewed by the senior dispensary technician and any actions followed up. The pharmacy did not have dedicated consultation facilities, but the hatch area offered some privacy for patients when collecting medication and conversations could not be overheard there. Access to the pharmacy was restricted to pharmacy staff using swipe cards. The pharmacy department was locked and alarmed when closed and only accessible to on-call pharmacy staff. The department had installed access control systems into the dispensary, distribution areas and the Controlled Drug room so that different area could be alarmed separately.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's services are easily accessible to a wide range of people. It manages the service 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 and was signposted from the reception area. The pharmacy was open 7 days a week throughout the year and had business continuity plans in place should any systems go down. Patients could contact the pharmacy by phone and information was included in prescription bags with contact details of the pharmacy medicines helpline number. The pharmacy was able to produce large print labels for patients with poor sight, had access to translation services. The pharmacy was also able to offer bilingual labelling in 7 languages. An induction loop was available should patients require this. The was a screen in the waiting area showing the progress of prescriptions using the tracking system so waiting times and patient expectations were managed.

The registerable activity in the pharmacy included the supply of some medicines on a named patient basis for a dialysis centre on site which was part of Imperial College Healthcare. The pharmacy dispensed around 70 items a month for the dialysis centre and the team would screen the prescriptions, which would then be dispensed, checked and then supplied either directly to patients or to nurses collecting on their behalf. If there were any queries with these prescriptions, the team could either follow the guidelines provided or contact the team at Imperial College Hospital for clarification. There were clear working processes where work would be prioritised, tasks were allocated to different staff members.

All supplied medicines were labelled appropriately, and all high-risk medicines were double checked prior to issue, including all insulin preparations and all oral cytotoxics. Anticoagulants were only given to patients by pharmacists who counselled them and answered any questions they may have. 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. All pharmacy staff were required to undertake counselling logs on induction before being able to hand over medication to patients.

The pharmacy sourced stock from licenced manufacturers who were reviewed to provide assurances that they met the wholesaler dealer's authorisation (WDA) regulations. All unlicensed medicines have undergone a technical risk assessment prior to acceptance for use in the Trust and there was a database containing the outcomes of those reviews. Medicines were stored in controlled environments and monitored continuously. The dispensary had air conditioning to keep all medicines in the acceptable temperature range and there was an electronic temperature monitoring system to monitor ambient and cold storage areas. This system provided alerts to Quality Assurance staff and on-call staff outside normal working hours. Fridge lines were mainly stored in a walk-in cold room, but there were fridges dedicated to prescriptions awaiting hand out and very high strength insulins. 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 and was compliant with the

European Falsified Medicines Directive (FMD). The Trust had implemented an FMD policy which managed through the pharmacy.

The pharmacy held a waste contract and medicines that had been returned to the department were segregated and sorted prior to disposal. Drug alerts and recalls were managed by the Quality Assurance team and the purchasing team. Any following action 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. Expiry date checks were undertaken on a rolling basis.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs for the delivery of its services. It looks after this equipment to ensure that it works properly.

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. The Trust had framework contracts in place for reputable suppliers of equipment. Up-to-date reference sources were available such as a BNF, a BNF for Children, and a Drug Tariff as well as other pharmacy texts and the pharmacy were supported by a medical information team. Internet access was also available should the staff require further information sources.

A self-inspection programme was in place for all areas as part of the Quality Management System (QMS) required by other external regulators for the sterile and non-sterile manufacturing, aseptic service, pharmacy stores and distribution. There were suitable pharmacy facilities including a CD room, cold room and fridges used for medicines storage. There were maintenance contracts for the refrigerators and the air conditioning systems. Designated bins for the disposal of waste medicines were available for use and the team also had separate bins for the disposal of hazardous waste.

All computer screens were suitably located and access to computers containing patient data was protected using individual passwords which were changed every three months. and staff had smart cards to access Summary Care records. All data was saved on secure servers.

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.