General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: LP HCS, Outpatients Pharmacy, Royal Berkshire Hospital FT Trust, London Road, READING, Berkshire, RG1 5AN

Pharmacy reference: 1105525

Type of pharmacy: Hospital

Date of inspection: 05/09/2024

Pharmacy context

This is an outpatient pharmacy in the Royal Berkshire Hospital in Reading. The pharmacy is owned and run by Lloyds Pharmacy as a separate legal entity. Its main activity is to dispense outpatient prescriptions. And it sells a limited range of over-the-counter medicines and other personal care products. The pharmacy also supplies medicines to the hospital's oncology clinics. The hospital also has a separate inpatient pharmacy not covered by this inspection.

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	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 has suitable written procedures in place to help ensure that its team members work safely. And the team understands and follows them. The pharmacy has insurance to cover its services. And it completes the records it needs to by law. The pharmacy team knows how to protect the safety of vulnerable people. And it protects people's confidential information properly. The pharmacy suitably identifies and manages the risks associated with its services. Team members respond effectively when mistakes happen. And they take suitable action to prevent mistakes in the future.

Inspector's evidence

The responsible pharmacist (RP) worked regularly at the hospital. And she deputised for the pharmacy manager in her absence. The pharmacy's main activity was its prescription dispensing service. And it dispensed prescriptions for people who had attended one of the hospital's many outpatient clinics. The RP described how she and her other pharmacist colleagues generally highlighted and discussed dispensing 'near misses' and errors as soon as possible with the team member involved to help prevent the same mistakes from happening again. The team recorded its mistakes. And it reviewed them each week and again every month, using the pharmacy's 'safer care' system. It reviewed them to analyse what had gone wrong. And any trends that may be developing. When a pharmacist identified a mistake, they or the team member involved recorded it on the near miss log. The system required team members to identify the type of mistake. And the reasons for it. The pharmacy manager then reviewed the records monthly. The inspector and RP agreed that it was important to reflect on what action team members would take to prevent a re-occurrence. Including thorough checks between the item, the label and the prescription.

The team also had a safer care board on display. And it used the board to highlight any issues for discussion at their safer care meetings. Such as ensuring that fridge doors were closed properly. And to check open packs. The team had been made aware of the risk of confusing look-alike sound-alike medicines (LASAs). This included Nitrofurantoin 50mg tablets and capsules. It had done this to reduce the risk of selecting the wrong medicine. The team recognised that preventing such mistakes required on going monitoring and intervention. It was clear that the team discussed what had gone wrong. And it acted in response to its mistakes. Team members agreed that near misses should lead them to identify the steps they could introduce to their own procedures to help them learn and improve.

The pharmacy had a set of up-to-date standard operating procedures (SOPs) for its team members to follow. SOPs were regularly reviewed. And recently updated SOPs were in the process of being read by staff. Team members understood their roles and responsibilities. And they followed the appropriate procedures for selling pharmacy medicines and general items. And when handing out people's prescriptions. The medicines counter assistant (MCA) asked people appropriate questions before selling a medicine or handing out a completed prescription. And she asked a pharmacist for their expertise when she needed it. She did this to ensure that people got the correct medicine or treatment. The dispensing assistants (DAs) worked with pharmacists to get prescriptions ready for people. And they consulted them when they needed their advice and expertise. They asked people appropriate questions about their prescriptions, to ensure they got the information they needed. And they accessed, used and updated the pharmacy's electronic records competently. The RP placed her RP notice on display showing her name and registration number as required by law.

People gave feedback directly to team members with their views on the quality of the pharmacy's services. The pharmacy had a complaints procedure to follow. And the team knew how to provide people with details of where they should register a complaint if they needed to. This included details for the superintendent's (SIs) office. If necessary, they could also obtain details of the local NHS complaints procedure online. But the team usually dealt with any concerns at the time. The RP commented that since recruiting additional staff, people no longer had to wait as long when they came to collect their medicines. The team worked closely with clinicians and nursing staff to arrange for alternatives when they received a prescription for an item that they could not get. And they also worked with the NHS procurement team to secure supplies of essential medicines which were in short supply. The pharmacy was very busy. And the team was observed handling people's queries well. And the DAs were observed assisting one another when needed. The pharmacy had professional indemnity and public liability arrangements so it could provide insurance protection for the pharmacy's services and its customers.

The pharmacy kept its records in the way it was meant to, including its RP records, its records for private prescriptions. And its CD register. The pharmacy kept a record of its CD running balances. And a random sample of CD stock checked by the inspector matched the running balance total in the CD register. It had a controlled drug (CD) destruction register. So that it could account for the receipt and destruction of patient-returned CD medicines. This was complete and up to date. The pharmacy did not generally have cause to make any emergency supplies. And so, it did not have any records to show. The team understood that it must ensure that all the pharmacy's essential records were complete and up to date.

The pharmacy's team members understood the need to protect people's confidentiality. And they had completed appropriate training. They shredded confidential paper waste throughout the day, as they worked. And they kept people's personal information, including their prescription details, out of public view. The pharmacy gave people a number for their prescriptions. And they called out the number when their medicines were ready. And made further cross checks with people before handing the medicines to them. They did this to help protect people's confidentiality from a busy waiting room of people. The pharmacy had a safeguarding policy. And pharmacists had completed appropriate training. Remaining team members had read the policy and had been briefed. And they knew to report any concerns to the pharmacy manager. The team had placed a notice with details for the relevant safeguarding authorities on the wall for easy access. And team members knew that they could also access up-to-date details online. But the pharmacy had not yet had to make any safeguarding referrals.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy team has an appropriate range of skills and experience to support its services. And it manages its workload safely and effectively. Its team members support one another well. And they keep their knowledge up to date. Team members receive sufficient feedback to help them carry out their tasks satisfactorily. And they feel listened to when they raise concerns.

Inspector's evidence

The responsible pharmacist (RP) was one the regular pharmacists. She had worked at the pharmacy since qualifying. And she deputised for the pharmacy manager as RP in her absence. Other team members present included a second regular pharmacist and a locum. Pharmacists were supported by a trainee technician, four dispensing assistants. And two MCAs. One of whom was about to start studying for a pharmacy degree. The pharmacy was on top of its workload. And its daily prescription workload was in hand. The team kept on top of its other tasks. And it dealt promptly with people waiting for prescriptions or advice. The team generally worked to a waiting time limit of 20 minutes. But the RP described how they would go over that time limit if circumstances required it. And when that happened team members would offer people a delivery service.

The team had two separate work streams. One team specialised on dispensing prescriptions for oncology patients. And the other team concentrated on prescriptions for outpatients from other clinics. Those dispensing oncology prescriptions had undertaken additional training. And until they had the required knowledge and skills, they had been closely supervised by the pharmacy manager. Oncology DAs were observed supporting each other and assisting with queries. And they consulted the RP when they needed her help. Or one of the other appropriately trained and skilled pharmacists.

Staff described feeling supported in their work by their colleagues and line managers. And they also felt supported by consultants, clinicians and nursing staff when they needed clarification or verification on a prescription issue. Or if they had a query. Team members worked effectively with one another. They described being able to have one-to-one meetings with the pharmacy manager or one of the other pharmacists, as they worked, or in private. Team members described how they had got together to review the way in which they managed the prescription workflow. They did this to ensure that they could get people’s prescriptions ready for them more quickly. Pharmacists made day-to-day professional decisions in the interest of people. And they did not feel under pressure to meet any business targets.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy's premises provide an environment which is appropriate for people to receive its services. And they are sufficiently clean, tidy and secure.

Inspector's evidence

The pharmacy was on the ground level of the outpatients' block. And it had step-free access. It was clean, properly lit and well maintained. It had a cleaner who cleaned the pharmacy's worksurfaces and floors regularly. The cleaner worked when other staff were present to supervise. The pharmacy's team members also cleaned touch points including keyboards regularly. The pharmacy had a small customer area with a consultation room. And it had a large waiting area for people waiting. The pharmacy displayed a core range of pharmacy medicines on the backwall behind its medicines counter. The counter sat alongside the dispensary. And one of the pharmacists' workstations sat at right angles to the counter. And so, the pharmacist working here could see people waiting. And if the MCA needed assistance. In general, the team completed their dispensing tasks without interruption from people.

Entry into the registered pharmacy premises was restricted to authorised personnel. And it had a secure access system directly into the dispensary. The dispensary had several workbenches along its perimeter and across several benches on central dispensing islands. And it used its pull-out drawers for storing medicines. It had other storage areas on shelving throughout the dispensary. At the time of the inspection, room temperatures were appropriate to keep staff comfortable and were suitable for the storage of medicines. The pharmacy had a small staff area. And team members had access to other staff facilities which it shared with other hospital staff. The hospital had a separate pharmacy for inpatients, which was run by the trust. But the two pharmacies often consulted each other.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides its services safely and makes them accessible to the people who use them. It supports the team's fellow healthcare professionals with suitable advice and medicines information. And it ensures that it supplies its medicines with the information that people need to take their medicines properly. The pharmacy team gets its medicines and medical devices from appropriate sources. And team members make the necessary checks to ensure they are safe to use and protect people's health and wellbeing.

Inspector's evidence

The pharmacy's principal activity was to provide services to the hospital's outpatient clinics and its chemotherapy wards. And to provide people with take home medicines prescribed at the clinics. It could also supply medicines against private prescriptions, but it rarely received any. People visited the pharmacy to have their prescriptions dispensed. And on occasion other healthcare professionals visited the pharmacy to collect prescribed medicines on behalf of patients. The pharmacy had written guidelines to help team members deliver services safely and efficiently. And it worked closely with the inpatients pharmacy team to ensure that it could fulfil people's prescriptions and manage medicines shortages. And the team worked hard to ensure that people's medicines were dispensed and supplied in good time. And in general, it supplied them either the same day or the day after, depending on when the prescription had been received. And the availability of the medicine prescribed. Prescriptions were usually generated electronically by prescribers. And on receipt at the pharmacy the system alerted the team to its arrival. And so, the team could see the number of prescriptions waiting to be dispensed at any time. The number of prescriptions waiting in the queue varied throughout the day but generally peaked during and after clinic times. Pharmacists were available to support clinicians with prescribing decisions and to support them to provide the most appropriate medicines for patients.

The pharmacy team signed its dispensing labels to show who had assembled the items and who had completed the final accuracy check. The pharmacy kept all its items in their original containers. And it dispensed most of them as complete packs. It also checked the expiry dates of its medicines regularly. The pharmacy had procedures for counselling patients on high-risk medicines, including chemotherapy medicines, anti- coagulant therapy. And medicines for rheumatology and dermatology. It provided additional counselling to ensure people understood how to take their medicines properly and safely. The team member questioned was also aware of the risks to women taking valproates who could become pregnant. Although the pharmacy had not dispensed valproate prescriptions for anyone in the at-risk group, it had stocks of the information leaflets and cards to help advise them. And described how they only dispensed full packs complete with their warning cards. They also knew not to stick the dispensing label over the manufacturer's warnings on the packaging.

The pharmacy obtained its medicines and medical devices from suppliers holding the appropriate licences. And the team stored its medicines, appropriately. And stock on the shelves was tidy and organised. The pharmacy checked the expiry dates of its stocks, regularly. And it kept records so that team members knew what had been checked. And when. This meant that the team could monitor the pharmacy's entire stock for expiry dates effectively. When the team identified any short-dated items it highlighted them. And a random sample of stock checked by the inspector was in date. The pharmacy had suitably designated bins for unwanted medicines, which were sealed when full and taken away for

destruction by the hospital. The team also used the appropriate waste bins for any hazardous waste such as cytotoxic medicines. The team stored its CD and fridge items appropriately. And it monitored its fridge temperatures to ensure that the medication inside it was kept within the correct temperature range.

The pharmacy received alerts and recalls direct from the MHRA. And internally from the hospital's medicines alerts system. It recorded details of all the alerts and recalls with details of the action taken, who by and when. And it let the hospital's clinicians know of any relevant stock affected by a recall. But the team had not had any stock affected by recent recalls.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has suitable facilities for the services it provides, and it makes sure that they are correctly used and maintained. It also ensures that people's private information is kept safe and secure.

Inspector's evidence

The pharmacy had suitable equipment available for measuring out loose tablets and capsules and for liquids. And its equipment was clean. And it had online access to multiple reference sources. Access to the pharmacy's computer systems was password protected and no screens were visible to people who did not work in the pharmacy. Computers had a time-out function to ensure they did not remain accessible when unattended for any length of time. Team members understood the importance of using their own smart cards. And they understood that this was necessary to ensure that they each had the appropriate level of access to records for their job roles. And to maintain an accurate audit trail. The pharmacy had cordless telephones to enable team members to hold private conversations with people. And it stored its prescriptions in the dispensary out of people's view.

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.