General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: The Christie Pharmacy, Wilmslow Road, MANCHESTER, M20 4BX

Pharmacy reference: 1116189

Type of pharmacy: Hospital

Date of inspection: 26/06/2019

Pharmacy context

The pharmacy is located inside The Christie Hospital in the suburb of Withington, South Manchester. It is a subsidiary of The Christie NHS Foundation Trust, which specialises in cancer care, research and education. The pharmacy supplies medicines to both inpatients and outpatients receiving treatment at the hospital and through Christie at Home.

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	1.2	Good practice	The pharmacy carries out regular checks to make sure that written procedures are being followed and to help identify areas for improvement.
2. Staff	Standards met	2.4	Good practice	Pharmacy team members participate in shared learning and get regular feedback on their performance, so that they can learn and make improvements.
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. It carries out regular checks to make sure that written procedures are being followed and team members complete tasks safely. And it keeps the records it needs to by law. The pharmacy seeks feedback from people and uses it to try and make improvements. And pharmacy team members complete training and understand how to keep people's private information safe.

Inspector's evidence

A range of standard operating procedures (SOPs) were in place to cover operational tasks within the pharmacy. Several of the procedures had a documented review date of December 2018. The superintendent pharmacist (SI) confirmed that the procedures were the most up to date versions and reported that the Trust Drug and Therapeutics Committee (DTC) had placed a stay of absence on the procedures, approving them for continued use. Team members had read and signed the procedures to confirm their acknowledgement. They were informed of any relevant SOP updates at weekly staff meetings, following the ratification of any changes at a monthly board meeting. The SOPs were used in conjunction with a Medicine Practice Operational Policy, which had been agreed with the Trust and contained the details of relevant treatment protocols.

The pharmacy was subject to regular external audits to demonstrate to the Trust that policies and procedures were being effectively implemented. Recent audits included a governance review, risk management review and regulatory review. A rating of 'substantial assurance' had been achieved in each audit. In one instance, an audit reviewing 'procurement for safety' had achieved an outcome of 'limited assurance'. An action plan identifying areas for improvement was completed and implemented and a repeat audit took place at six months.

Near misses were recorded on an ongoing basis. Records contained limited details of specific medications involved and any contributing factors, often just recording the date and type of near miss, as well as the team member involved. This may mean that some opportunities to identify patterns and trends are missed. The logs were reviewed at weekly intervals and feedback was regularly provided to the pharmacy team, and, one-to-one feedback was provided if individual learning needs were identified. Dispensing incidents, along with some near misses which were classified as 'severe' were recorded through a Datix system. Incidents were reviewed by individuals including consultants, the Trust chief pharmacist and the pharmacy management team. The SI discussed the action that had been taken in response to a previous delivery error, where he had also liaised with the head of the Trust estates department.

A complaint procedure was in place and people using pharmacy services were also able to raise concerns through the NHS Patient Advice and Liaison Service (PALs). Concerns were reviewed by the SI. Feedback was also received through questionnaires, which were available in the pharmacy waiting room and throughout the hospital. Any issues raised were discussed at a monthly board meeting.

Indemnity insurance arrangements were in place through the National Pharmacy Association (NPA). A responsible pharmacist (RP) notice was displayed at the main reception hatch, relevant RP information was also displayed on a computer screen in the waiting area. The RP log was in order. Controlled drugs (CD) registers kept a running balance and regular checks were conducted. Patient returned CD registers were also in use. The pharmacy did not dispense any private prescriptions or provide emergency supplies, so no records were available. Specials procurement records were retained and archived. An audit trail from source to supply was available through the patient medication record (PMR).

Pharmacy team members had completed training on the General Data Protection Regulation (GDPR) and confidentiality. The pharmacy had also completed a data security audit. Confidential waste was segregated from general waste and removed for appropriate disposal. No confidential information was visible from the main reception desk and completed prescriptions were stored out of view.

Registrants had completed safeguarding training, but there was limited training for other team members, which may mean that they are not always able to effectively identify safeguarding concerns. The SI agreed to review this post-inspection.

Principle 2 - Staffing ✔ Standards met

Summary findings

Pharmacy team members work in an open environment and there are enough staff to manage the current workload. Pharmacy team members complete planned training to make sure they keep their knowledge and skills up to date, and they get regular feedback on their development.

Inspector's evidence

The pharmacy employed a large team and had a varied skill-mix to enable tasks to be completed effectively and efficiently. Several rotas were pre-planned to ensure that there was an appropriate staffing level for the workload, these were reviewed daily in response to any unplanned changes, such as sickness. Restrictions were placed on leave to help ensure that staffing levels were sufficiently maintained. Requests were submitted through an electronic system and were approved by management.

Upon employment team members completed an induction programme and were provided with a staff handbook. A number of mandatory training modules including fire training, hand hygiene and working at heights were completed along with GDPR training. Following the completion of mandatory topics, the SI assigned further training modules on an ongoing basis, as a need was identified. Team members were alerted to any new modules to complete when they logged into their individual e-Learning platform and time was provided to support the completion of training. Protected training time was also given to trainee members of the team who were completing accredited training programmes such as the NVQ level 3 pharmacy technician programme. Pharmacy team members were also able to attend regular lunchtime training meetings, which were held by the clinical lead for the hospital Trust. Different clinical topics were covered at each meeting and registration with British Oncology Pharmacy Association (BOPA) was encouraged to further support development. Feedback was provided to the team on an ongoing basis. Any identified issues were addressed with management and additional support was put into place, such as the completion of logs, should an increase in errors be identified. Feedback on development was also provided through annual appraisals and NVQ trainees had regular development reviews with their tutors and training providers.

The team worked in an open environment and the SI said that an ‘open door’ policy was in place. Several staff representatives held regular meetings with management and the SI could raise any further issues at a monthly board meeting. Additional staff support services were available through an online management platform and a whistleblowing policy was in place to facilitate staff in raising concerns anonymously.

A number of key performance indicator targets were in place for inpatient and outpatient prescription dispensing times, incident reporting and additional HR related tasks such as appraisals and mandatory training, these were reviewed at monthly intervals.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy provides a clean, safe and secure environment for the delivery of pharmacy services. But a lack of consultation facilities may mean that people do not always have access to a private area for confidential discussions.

Inspector's evidence

The premises were well maintained and portrayed a professional appearance. Maintenance issues were escalated to the Trust maintenance team and assistance with daily cleaning duties was also provided.

The waiting area to the front of the pharmacy had several chairs for use by patients and the main glass hatch was separated into three individual sections. One for people presenting to the pharmacy and two for prescription handout. Privacy screens were in place help provide segregation and retractable belt barriers were used to create lines for people to wait. But there was no enclosed area for patient counselling. Team members were observed to do their best to maintain privacy when handing out prescriptions, but the waiting area was continually busy, and conversations could be overheard which could potentially breach patient confidentiality.

The dispensary had adequate space for the provision of services. There was a clear and defined workflow through the dispensary, with separate areas for clinical checking, dispensing and accuracy checking. A separate work bench was also available for the assembly of any prescriptions containing cytotoxic medications. The dispensary had a sink which could be used for the preparation of medicines and numerous large shelving units were used for medicine storage. A separate stores area was also well maintained.

There was adequate lighting throughout the premises and air conditioning provided a temperature appropriate for the storage of medicines.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's services are accessible and well managed so that people receive appropriate care. The pharmacy sources and stores medicines securely and team members carry out regular checks to make sure that they are suitable for supply.

Inspector's evidence

The pharmacy was clearly signposted throughout the hospital and had step-free access making it accessible to people with mobility issues. Additional adjustments could be made for those with different needs, such as the use of large print labels from the PMR system. Information including pharmacy opening hours was available in the waiting area, but other health promotion literature was limited.

An electronic prescribing system was in operation. Prescription details were retrieved and assigned a barcode, which was used for tracking. People waiting for their prescription were provided with a number and screens were positioned in the waiting area and in the hospital restaurant, so that people were able to view the progress of their prescriptions. Prescriptions were clinically checked by pharmacists, who had completed additional training provided by the Trust to ensure that they had the necessary skills to check chemotherapy. Records of this training were kept for reference. Prescriptions were then dispensed and checked in designated areas. An audit trail was maintained for all checks, so that those involved in processes could be identified. The team had access to clinical systems which recorded the details of any monitoring parameters such as blood test results. Monitoring and safety literature including yellow anticoagulant books, a Trust capecitabine card and valproate warning information was available and team members demonstrated a knowledge of the MHRA guidance relating to supplies of valproate-based medicines in patients who may become pregnant.

Stock medicines were sourced through reputable wholesaler and specials from a licensed manufacturer. Stock medicines were stored in dispensing robots and on shelves within the dispensary. Medicines were in the original packaging provided by the manufacturer and date checking was conducted on an ongoing basis, to ensure that medicines were suitable for supply. Out-of-date and returned medicines were disposed of in appropriate waste receptacles, including a cytotoxic waste bin for hazardous materials. The pharmacy was not currently compliant with the requirements of the European Falsified Medicines Directive (FMD). The SI confirmed that the necessary hardware and software had been procured but said that Trust approved, and secured computers were required for implementation. These were due to be installed within the coming weeks.

CDs were stored appropriately with out of date and returned CDs segregated from stock. CD denaturing kits were available. Several refrigerators were subject to 24 hour temperature monitoring. Alarms were activated should the temperature fall outside of the recommended range, including out of hours.

Alerts for the recall of faulty medicines and medical devices were received from the MHRA. Alerts were actioned as appropriate and an audit trail was maintained.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has access to the equipment it needs to deliver its services safely.

Inspector's evidence

Access was available to paper-based pharmaceutical reference sources and additional electronic resources, such as Medicines Complete. Internet access supported additional research and team members were also provided with access to Trust internal databases, for further patient specific clinical information.

Several crown-stamped and ISO approved measures were available. But the pharmacy also used a number of plastic measures which were not British Standard approved and might lead to some inaccuracies when measuring liquids. Counting triangles were available for loose tablets, with separate equipment marked for use with cytotoxic medicines. The dispensing robot was regularly serviced, and team members had access to a helpdesk facility.

Electrical equipment underwent routine PAT testing and was in working order. Computer systems and PMR access was password protected. Screens were located out of public view and cordless phones were available to enable conversations to take place in private.

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.