General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Opd St Thomas, St. Thomas's Hospital, Lambeth Wing, Lambeth Palace Road, LONDON, SE1 7EH

Pharmacy reference: 1116287

Type of pharmacy: Community

Date of inspection: 02/08/2023

Pharmacy context

This pharmacy is located within a hospital in Southeast London and serves people from a wide geographical area. It is a busy pharmacy, and it dispenses medication for outpatients and sells medicines over the counter.

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	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 manages its risks appropriately to make sure people are kept safe. It largely keeps the records it needs to by law, so it can show that supplies are made safely and legally. Team members get training, so they know how to protect vulnerable people and the pharmacy manages and protects people's confidential information appropriately. People who use the pharmacy can provide feedback about the pharmacy's services.

Inspector's evidence

Standard operating procedures (SOPs) and Trust policies were available. Members of the team had signed individual record sheets to confirm they had been read and understood the SOPs. The pharmacy manager arranged cover to ensure team members were able to complete reading the SOPs as well as any training on eLearning. SOPs were read by all new team members as part of their induction.

Near misses, where a dispensing mistake was identified before the medicine was handed to a person, were documented as they occurred. The pharmacy manager handed back mistakes as they were identified to the team member who had dispensed the prescription who rectified their mistake and recorded the mistake. Near misses were seen to be recorded, at the end of each month they were reviewed by the regional manager. As the robot was used to dispense prescriptions, picking errors were rare. Liquids, injections and external preparations were not placed in the robot. The pharmacy manager described that there were codes which were used as part of the labelling system which had also reduced the number of near misses. The pharmacy manager did audits each week which were known as 'Safer Care' audits. Different areas were audited each week which included the environment, people, and processes. A team briefing was held in the fourth week. Dispensing mistakes which had reached a person (dispensing errors), were recorded on the Lloyds internal system 'PIMS' and on Datix. There was a step-by-step process for Datix, and the pharmacy also had a guide on making PIMs entries. Reports were either done by the pharmacists or operational managers. Locum pharmacists were not usually left to work on their own and where available Lloyds relief pharmacists were used. CD incidents and incidents were there was a 'high' level of harm caused had to be reported on Datix straight away and other incidents had to be reported within 24 hours. Datix also gave a date by when the report needed to be closed following investigation. The pharmacy also received an email if a Datix entry had been made by another department which was related to the pharmacy, and they were required to complete their reporting. At the end of each month a report was generated which was sent to the regional manager who discussed it at a trust meeting. Weekly meetings were held with the operational manager, pharmacists from each site and the Trust's complaints team to discuss any incidents. The regional manager also had regular meetings with the chief pharmacist and then briefed the team at the pharmacy meeting.

A dispenser explained that if they had dispensed incorrectly and the mistake was picked up by the pharmacist when checking it was handed back to them. If there was a labelling error, it was corrected when returned and entry was made in the log. The reason as to how the mistake had happened was also recorded. In the past due to mistakes team members had been asked to avoid distractions. The dispenser said dispensing errors did not normally occur. In the instance that it had they would call the person, courier out the correct medication and retrieve the wrong medication. The dispenser was aware that errors needed to be reported on PIMS.

The pharmacy had current indemnity insurance cover. The correct responsible pharmacist (RP) notice was displayed. Samples of the RP record were seen to be well maintained. The pharmacy did not dispense private prescriptions or provide emergency supplies. Records for unlicensed medicines seen were not completed. The pharmacy manager and operational manager provided an assurance that these would be kept in future. A sample of controlled drug (CD) registers was inspected, and these were filled in correctly. The physical stock of a CD was checked and matched the recorded balance.

A complaints procedure was available, and people were able to give feedback or raise concerns online or verbally. Most complaints were received via Datix and were investigated with feedback uploaded. All complaints were also logged on to PIMS.

Team members had completed training on the Information governance policy and data protection. Confidential waste was collected in a separate bag and computers were password protected. A consultation room was available for private conversations. Team members had completed online training on safeguarding children and vulnerable adults. Team members said they would report concerns online and to the Trust.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough staff to operate effectively. Staff are trained or in the process of completing the necessary training for their roles. There are contingency plans for when team members are off work. Team members are provided with ongoing training to help keep their knowledge and skills up to date. The pharmacy team can provide feedback and concerns relating to the pharmacy's services.

Inspector's evidence

At the time of the inspection the pharmacy team comprised of the pharmacy manager, a second pharmacist, two trained locum dispensers, two trained dispensers, a trained healthcare assistant (HCA), a trainee HCA and a work experience student. A third pharmacist started her shift during the inspection. Team members were either trained or were in the process of competing their training. The team were seen to be able to manage their workload during the inspection. The aim was to handout prescriptions within 15 minutes of them being handed in by people, this was seen to be 'green' during the inspection. Four dispensers had left, two dispensers had been hired and the pharmacy were in the process of hiring an additional two dispensers. A new pharmacist was also due to start working at the pharmacy the week after the inspection after which there would be three pharmacists covering at all times. At the time of the inspection locum dispensers were being used to cover the dispenser vacancy. The pharmacy manager had taken over the role a month before the inspection. He had previously worked at a Lloyds pharmacy in a supermarket and had undergone a one-month induction period. The previous pharmacy manager had left their role in February 2023 and between February and June there had been a site manager. The pharmacy had recently recruited a new operations manager who worked across the group's sites at both Guys and St Thomas. The operations manager was present during the inspection and explained that she had made a number of changes at the other site and was due to move to the St Thomas site.

The Trust was due to move to a new electronic system in October. As part of this the pharmacy needed to employ more staff. The operations manager explained that at the time of the inspection there were 17 employed team members without the pharmacists, and this was due to be increased to 22. To cover leave or sickness, cover was arranged using staff from the Guys site or locums. Locum pharmacists and dispensers had all read the SOPs and relevant training. This included governance training and how to use the computer systems. The pharmacy had a pool of locums that were used and very rarely used locums outside of this.

New pharmacists underwent a two-week training plan at the Guys site when first joining. As part of this they read through SOPs, completed the relevant eLearning training modules and went through the governance guidelines as well as training on using the computer systems.

The HCA asked appropriate questions before making over-the-counter sales and referred to the pharmacist if unsure. She described the processes for taking in and handing out prescriptions which was in line with written procedures.

As the new pharmacy manager had only started working at the pharmacy a month before the inspection, he was due to set up performance and learning plans with team members. However, team members were provided with on-the-spot feedback. Team members completed ongoing learning on

the eLearning platform and were given time to complete this. Progress was tracked by the manager who confirmed that the team were all up to date with their training.

Team members discussed issues as they arose, and information was shared on the group chat. Clinical governance meetings were held with the Trusts team and management team on a regular basis. Team members felt able to provide feedback and give suggestions to their manager. The team had a target of 15 minutes from the time prescriptions were handed in for them to be screened, processed and handed out. This target was set by the Trust. The managers were provided with a daily report which included the number of items dispensed and the number within the target time. This needed to be at least 75%. The operations manager explained that sometimes calling clinics to confirm information took time, but the pharmacy usually met their target. Feedback on waiting times was passed on to the team by the manager. Targets did not affect the professional judgement of the team.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy's premises are clean, secure and generally provide an appropriate environment to deliver its services. People can have a conversation with a team member in a private area. But the pharmacy could do more to make sure that it keeps its floorspace clear to prevent trips.

Inspector's evidence

The pharmacy was well laid out and clean, the retail area was organised. Workspace was organised and allocated for certain tasks with dedicated workbenches for dispensing, checking, screening. Dispensing benches had limited space. An area at the side of the dispensary was allocated to sorting and dealing with the courier service. A contract agreement was in place with the hospital and cleaners came into clean the pharmacy daily and team members also helped with cleaning. A clean sink was also available. Medicines which were not stored in the robot were stored on shelves in a tidy and organised manner. The pharmacy had a stock room downstairs which was alarmed and only accessible to pharmacy staff. There were a number of boxes containing bags with uncollected prescriptions. This reduced the floor space in parts of the dispensary which already had limited space.

A signposted consultation room was available; the room was locked when not in use and was used mainly for private discussions. The room was clean. Confidential information held within the room in lockable drawers.

The ambient temperature and lighting were adequate for the provision of healthcare. Air-conditioning was available to help regulate the temperature.

Principle 4 - Services ✔ Standards met

Summary findings

Overall, the pharmacy provides its services safely. People taking higher-risk medicines are provided with the information they need to take their medicines safely. It obtains its medicines from reputable sources and manages them appropriately so that they are safe for people to use. It takes the right action in response to safety alerts so that people get medicines and medical devices that are safe to use. People with a range of needs can access the pharmacy's services.

Inspector's evidence

There was easy access to the pharmacy, and it was well signposted. The consultation room also had a wide door and was accessible to wheelchairs. Some people were brought to the pharmacy by the porters, team members said there was lots of space and they were given priority. After the person had been given their medication, the team would rebook another porter for them. The team were able to produce large-print labels and a hearing loop was also available.

Most of the team were multilingual and the pharmacy had access to the Trust's over the phone interpreter's service. The team had used the service in the past and also used online translation software. People were signposted to other services where appropriate; and a list of other services was available.

HCAs confirmed the person's details and asked several questions when taking in prescriptions, including allergy status and medical history. Prescriptions were ticked by the HCAs to confirm that checks had been made. They were booked into an electronic system and people were provided with a numbered ticket. They were then placed in colour-coded trays to allow the team to prioritise prescriptions. The trays were placed in a designated area for the pharmacist to screen. The RP checked the dose, indication, length of supply and if the medicine was in the formulary. They were then handed to a dispenser who assembled the medicines and placed them in a designated area for another pharmacist to conduct a final check. An additional check was conducted by a third pharmacist for cytotoxic medication. Dispensed and checked-by boxes were available and were routinely used. Team members including pharmacists also initialled the bottom of the prescription slip to maintain an audit trail of who had completed each part of the dispensing and screening process. Approximately 90% of the time people waited for their prescriptions. People were counselled on the use of their medicines at handout.

The pharmacy did not receive many prescriptions for sodium valproate. The pharmacists were aware of the guidance for dispensing sodium valproate and the associated Pregnancy Prevention Programme (PPP) and described that the same checks were carried out when dispensing isotretinoin. These prescriptions were usually checked and screened by two pharmacists. Methotrexate was not handed out unless the person had their book available, and warfarin was not frequently dispensed.

People were contacted to arrange delivery of their medicines. The Trust used different couriers for deliveries. Deliveries were all booked on the system. Drivers had handheld devices which were updated as part of the delivery process. For urgent acute medicines, couriers signed a log to confirm that they

had collected the medicines from the pharmacy. Failed deliveries were returned to the pharmacy department who would then arrange another delivery. Team members said this was very rare as people were always called to arrange delivery.

Prescriptions for Hepatitis C patients were dispensed on instalment prescriptions. These prescriptions were screened by the trust pharmacist before being sent to the pharmacy. Prescriptions were generally for three months, and blood results needed to be updated. The team were informed of this by the Trust pharmacist.

The pharmacy used licensed wholesalers to obtain medicines and medical devices. Most of the stock was held in the robot. Team members manually put in stock when it was received. In the event that there was an issue with the robot medicines could still be removed. However, any issues were resolved relatively quickly. The team date-checked medicines for expiry regularly and kept records of when this had happened. Expiry dates for medicines were entered onto the robot as they were added. These were checked monthly, short-dated stickers were used to highlight medicines. Fridge temperatures were checked daily and recorded. These were observed to be within the required range for storing medicines. Out-of-date and other waste medicines were disposed of in the appropriate containers which were kept separate from stock and collected by a licensed waste carrier. Drug recalls were received on an internal system. Once actioned the system needed to be updated. Drug recall notices were also displayed in the dispensary. The last actioned alert had been for labetalol.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs for its services.

Inspector's evidence

The pharmacy had several glass measures and tablet counting triangles, including separate triangles for cytotoxic medicines. This helped avoid cross-contamination. There were several fridges in the dispensary. Waste medicine bins and destruction kits were used to dispose of waste medicines and CDs respectively. The dispensing robot was serviced once a year. Members of the team had access to the internet and several up-to-date reference sources.

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.