General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Fairview Pharmacy, Unit 10 Rockhaven, Triangle Park, Metz Way, Gloucester, Gloucestershire, GL1 1AJ

Pharmacy reference: 9011151

Type of pharmacy: Specialist hospital services

Date of inspection: 06/11/2019

Pharmacy context

This is a pharmacy on an industrial estate close to the centre of the city of Gloucester. It supplies services to local Gloucestershire community hospitals against hospital prescriptions. The pharmacy also supplies medicine in multi-compartment compliance aids to help vulnerable people in their own homes, discharged from hospital, to take their medicines. Most people who receive medicines from the pharmacy are elderly, but they also supply some specialist medicines to a wider variety of people.

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's working practices are generally safe and effective. It is appropriately insured to protect people if things go wrong. And, it keeps the up-to-date records that it must by law. The pharmacy team members protect people's private information and they know how to protect vulnerable people. But, whilst some procedures have been put in place to reduce the risk of mistakes, the team could do more to learn from these to prevent them from happening again. And, the written procedures are not specific to the business at the pharmacy. So, the team members may not be clear about how they are supposed to be working.

Inspector's evidence

The pharmacy was newly opened and had been operational since the end of April 2019. It mainly supplied medicines to local community hospitals. The pharmacy team identified and managed most risks. Dispensing errors and incidents were recorded, reviewed and appropriately managed. Following an error where an in-patient, with the same surname, had been supplied with the wrong medicines, the name of the patient was now initialled on the label and on the order sheet to demonstrate that this had been thoroughly checked. But, there had been 15 errors since the pharmacy starting trading. This equated to about 0.1% which would be considered high. Because of this, three independent people were now involved in the dispensing process to reduce the risk of errors. Near misses were recorded but insufficient information was documented to allow any useful analysis. No learning points or actions taken to reduce the likelihood of similar recurrences were recorded. The log had only been reviewed once since April 2019 and this was not documented. But, as a result of mistakes with the multi-compartment compliance aids, the backing sheets were now checked prior to the assembly to reduce the risk of errors with these.

The pharmacy was large and organised. There were clear designated areas: an administration area where the prescriptions were printed off, two labelling areas, four assembly areas, an area for prescriptions waiting to be checked, an area for any queries, an area awaiting original controlled drug (CD) prescriptions with a 'wet' signature, a large checking area, a delivery area and a goods inward area. Coloured baskets distinguished prescriptions for in-patients and those for patients to be discharged. There was a clear audit trail of the entire dispensing process and all the 'dispensed by and checked by' boxes on the labels examined had been initialled.

Up-to-date standard operating procedures (SOPs) were in place. But, these were not specific to the business, such as, the dispensing process and the complaints procedure. The pharmacy had no NHS contract but operated under a service level agreement with Gloucestershire Health and Care Foundation Trust. They also had a contract with Hope House Sexual Health Services, the sexual health service provider for Gloucestershire.

As mentioned above, the complaints procedure in the SOPs was not specific to the pharmacy. In practice, the pharmacy used the Trust's procedures. Complaints were entered onto Datix and escalated to the Lead Pharmacist for the Trust. A thorough investigation was done. Most complaints involved delays to patient discharge because of take home medicines (TTOs). The staff said that these were often due to discrepancies between the TTO prescription and the medication administration record (MAR) chart and to CD prescriptions not being correctly written. The staff spent considerable

time trying to sort these problems out, hence the delay in the supply of the medicines. Quarterly meetings were held with the Trust to discuss these issues.

Public liability and indemnity insurance provided by the National Pharmacy Association (NPA) and valid until 12 October 2020 was in place. The responsible pharmacist log, CD records, specials records, fridge temperature records and date checking records were all in order. The pharmacy received no patient-returned CDs. All the prescriptions were treated as private prescriptions and these were correctly and electronically recorded.

There was an information governance procedure and the staff had also completed training on the new data protection regulations. The computers were password protected. Confidential information was stored securely. Confidential waste paper information was collected for appropriate disposal.

The staff understood safeguarding issues and had all completed level 1 training provided by the Centre for Pharmacy Postgraduate Education (CPPE). The pharmacists and technicians had done level 2. Local telephone numbers were available to escalate any concerns. All the staff had completed 'Dementia Friends' training.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough staff to manage its workload safely. And, they are trying to recruit a further team member for flexibility and to accommodate the anticipated growth in the business. The team members are supported by their manager. They are comfortable about providing feedback to her to improve services. But, there are no formal appraisals and so some gaps in their skills and knowledge may not be identified and supported. And, the team members are not doing regular on-going learning. So, their knowledge may not be up to date.

Inspector's evidence

The pharmacy was on an industrial estate close to the centre of the city of Gloucester. It supplied services to seven local Gloucestershire community hospitals against hospital prescriptions, including some compliance aids for patients discharged to home. The pharmacy also supplied medicines to patients of Hope House sexual health clinic. Most of these were delivered to the clinic but a few patients came to the pharmacy to collect their medicines.

The current staffing profile was one full-time pharmacist based at the pharmacy plus two full-time and one part-time pharmacist based on the wards, one full-time NVQ3 qualified technician (also an accuracy checking technician), the manager, one part-time NVQ3 qualified technician based on the wards and two full-time NVQ2 qualified dispensers. They also employed two full-time delivery drives who visited the hospitals twice each day. The pharmacy was advertising for a further part-time qualified dispenser to allow for anticipated growth. The ward-based pharmacists spent some time working in the pharmacy

There was some flexibility to cover any unplanned absences and the proposed recruitment of a part-time staff member should help with this. Planned leave was booked well in advance and only one member of the staff could be off at one time. The other staff members would usually cover this with a re-arrangement of rotas. If necessary, locum help would be secured.

The staff were well qualified and worked well together as a team. Staff performance was monitored, reviewed and discussed informally throughout the year. But, currently, there was no formal appraisal process or formal induction process. The manager said that she would raise this issue with higher management. The staff were not signed up to any regular on-going learning programme to ensure that they kept their skills and knowledge up to date. The manager said that she would discuss this issue too. The GPhC registrants reported that all learning was documented on their continuing professional development (CPD) records.

There were no formal staff meetings although there were quarterly meetings with the higher management. However, all the staff seen said that they felt supported and able to raise any issues. They believed that any legitimate concerns or suggestions to improve services would be acted on. The pharmacy was currently discussing key performance indicators with the Trust.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy looks professional. The work areas are tidy and organised. The pharmacy has an area that is used for consultations but there is no dedicated room and so patient confidentiality may be compromised.

Inspector's evidence

The pharmacy was well laid out and presented a professional image. The work areas were spacious, tidy and organised. The dispensing benches were uncluttered and the floors were clear. The premises were clean and well maintained.

The computer screens were password protected. Very few patients presented in the pharmacy. Any such patients were counselled in the front reception area. Usually there was just one patient and so patient confidentiality should not be compromised. The manager said that she would discuss with the higher management about the possibility of having a dedicated consultation room.

There was air conditioning and the temperature in the pharmacy was below 25 degrees Celsius. There was good lighting throughout. No items for sale were offered for sale.

Principle 4 - Services ✔ Standards met

Summary findings

The services offered by the pharmacy are effectively managed to make sure that they are delivered safely. The pharmacy team members liaise with the hospitals to make sure that they are aware of any potential issues. Very few people come to the pharmacy. But, the team members make sure that, any people who do come, know how to use their medicines correctly. The pharmacy gets its medicines from appropriate sources. The medicines are stored and disposed of safely. The team members make sure that people only get medicines or devices that are safe.

Inspector's evidence

There was wheelchair access to the pharmacy, but in practice, only a few sexual health patients presented at the pharmacy. Almost all medicines were delivered to the appropriate hospital or to Hope House Clinic. The pharmacy had no NHS contract and no enhanced or advanced NHS services were offered. The pharmacy could print large labels for sight-impaired patients.

Stock was supplied to the hospitals under wholesale dealer authorisation (WDA) from the Medicines and Healthcare products Regulatory Agency (MHRA). There was a clear, spacious dedicated area for this. Most common medicines were supplied from ward stock, under the WDA. The pharmacy generally only supplied unusual medicines and this was against hospital prescriptions. The ward-based staff were responsible for medicines reconciliation on the wards to ensure that they had sufficient stock. Stock lists were used for this. The prescriptions that the pharmacy dispensed against, were sent electronically. Trust procedures were in place to ensure that only doctors could prescribe medicines. The pharmacy printed off the medicine administration record (MAR) chart and the order required. These contained the patient's name, ward number, NHS number and any allergies. A process map was added to the front of each prescription. This included a robust audit trail of the entire dispensing process. Any potential interactions were printed off. All the prescriptions were clinically checked prior to assembly.
Non-compliance aid TTOs were delivered the same day, if the prescription was received by 12 noon or, the next morning, if after noon. There was usually a 24-hour turn-around time for compliance aid TTOs. Several discharge domiciliary patients had their medicines in compliance aids. Two weeks supply of medicines was given. The MAR charts included a concise record of any changes or other issues. Patient information leaflets and medicine descriptions were included for all the compliance aids. The backing sheets for these were checked prior to picking and assembly because of recent transcription errors from the MAR charts to the prescription. In the event of discrepancies, the ward was called to discuss the issue. This often led to delays. Original signed prescriptions were received for CDs. But, these were often written incorrectly which also led to delays. The manager said that she planned to raise these issues with the Lead Pharmacist at the Trust.

The pharmacist checking bench had a displayed list of medicines that required extra care, such as, anticoagulants and non-steroidal anti-inflammatory drugs. The wards ensured that all patients prescribed high-risk drugs were having the required blood tests. But, sometimes they did not send the warfarin charts and sometimes INR levels were due in two days, but the pharmacy was expected to give 14 days supply. These issues sometimes resulted in delays to the timely receipt of the TTO medicines.

The pharmacist checking bench also had a displayed list of all the anti-viral drugs supplied to the human

immunodeficiency viral (HIV) patients of Hope House. Some of these patients collected their medicines from the pharmacy and the pharmacist provided any appropriate advice. All other routine counselling was done by the ward-based pharmacists. But, the pharmacy-based pharmacist would contact the ward of they were concerned about anything, such as recently, with Ferrinject infusion. There is a risk of anaphylaxis with this medicine and the pharmacist had rung the ward to make sure that they were aware of this risk.

Medicines and medical devices were generally obtained from AAH, Alliance Healthcare, Sigma, Phoenix and Colorama. Some items were obtained directly from the manufacturer. Few specials were supplied but these were usually obtained from Sigma. Invoices for all these suppliers were available. CDs were stored tidily in accordance with the regulations and access to the cabinet was appropriate. There were no out-of-date CDs. The pharmacy received no patient-returned CDs. Appropriate destruction kits were on the premises. Fridge lines were correctly stored with an automatic data logger and also signed records. Date checking procedures were in place with signatures recording who had undertaken the task. Designated bins were available for medicine waste and used. There was no a separate bin for cytotoxic and cytostatic substances but there was list of substances that should be treated as hazardous for waste purposes. Any such substances would be appropriately separated.

There was a procedure for dealing with concerns about medicines and medical devices. Drug alerts were received electronically, printed off and the stock checked. Any required actions were recorded. These were also stored electronically.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy generally has the appropriate equipment and facilities for the services it provides. And, contingency plans are in place in the event of electronic failures.

Inspector's evidence

The pharmacy had a British Standard crown-stamped conical measures (50ml). The other measures were only CE stamped. The manager gave assurances that she would get a selection of appropriate measures. There were three tablet-counting triangles, one of which was kept specifically for cytotoxic substances. These were cleaned with each use. There were up-to-date reference books, including the British National Formulary (BNF) 76 and the 2017/2018 Children's BNF. There was access to the internet and to the medicines information department at Gloucester Royal Hospital.

The fridge was in good working order and maximum/minimum temperatures were recorded daily. The pharmacy computers were password protected. The pharmacy had a back-up router in case of problems with the internet connection. Confidential waste information was collected for appropriate disposal.

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.