General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: LP HCS, Outpatients Pharmacy, University College Hospital, 235 Euston Road, London, NW1 2BU

Pharmacy reference: 9011185

Type of pharmacy: Community

Date of inspection: 08/02/2024

Pharmacy context

The pharmacy is near the main entrance of University College Hospital in northwest London. It dispenses prescriptions for outpatients, sells over-the-counter medicines and provides health advice.

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	1.1	Good practice	The pharmacy team manage the risks associated with providing services and protect the health and wellbeing of people who use the pharmacy.
2. Staff	Standards met	2.2	Good practice	Members of the pharmacy team are supported and encouraged in learning and development.
3. Premises	Standards met	N/A	N/A	N/A
4. Services, including medicines management	Standards met	4.2	Good practice	The pharmacy team has systems in place to identify prescriptions for high-risk medicines and make sure people have the information to use their medicines safely
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 has suitable standard operating procedures in place which the team follow to manage the risks associated with providing services. The pharmacy keeps the records required by law showing it supplies its medicines and services safely. It has systems in place for the team members to learn from their mistakes and take action to prevent them happening again. Members of the pharmacy team protect people's private information, and they are appropriately trained in how to safeguard the welfare of vulnerable people.

Inspector's evidence

The pharmacy had systems to review dispensing errors and near misses. Members of the pharmacy team reported mistakes on Datix which was a risk management information system to collect data on adverse events and response to the incident following investigation on behalf of the Trust and Lloyds. The pharmacy manager described a Datix entry for a 'no harm' incident where a medicine was supplied correctly but not in the prescribed form. And the learning point was related to the label information produced by EPIC. The pharmacy could identify learning points and reduce the chances of the same mistakes happening again. The pharmacy manager explained that the pharmacy regularly completed actions and records in the 'Safer Care' folder.to maintain a safe working environment in the pharmacy. The near miss review was included in Safer Care and 'lookalike and soundalike' (LASA) medicines were identified and highlighted. The pharmacy was clean and tidy, and the team training was up to date. Team members reported current safety information on the 'Safer Care' whiteboard such as medicines stock issues. Representatives of the pharmacy met with the Trust liaison pharmacist and chief pharmacist on a monthly basis and discussed patient safety incidents, key performance indicators and review o systems and processes.

The pharmacy used a computer system called EPIC to process the prescriptions. The pharmacy monitored its services and at the time of the visit, about 75% of people waited while their prescriptions were dispensed. All prescriptions were issued for hospital outpatients attending Accident & Emergency, day surgery cases and specialty clinics such as fertility, cardiology, dermatology or rheumatology. And were often for a short supply of medicine. The prescribers issued electronic prescriptions except for controlled drug (CD) prescriptions which were also issued as a paper hard copy.

All team members had their own log in details. When people presented at the medicines counter, they gave their date of birth or hospital number to confirm identity so the member of the team could bring up the person's record and prescription on EPIC. A member of the team issued a ticket number which was recorded on the patient medication record (PMR) on EPIC along with information such as allergies and medical history. The team members screening and dispensing the prescription could refer to the information. The prescription was in the pharmacy queue and was screened by a pharmacist who checked the dose, indication, length of supply and if the medicine was in the Trust formulary. The pharmacy team could not dispense a prescription until it was screened and clinically checked by a pharmacist. EPIC automatically generated dispensing labels from which the team picked medicines but also checking against the prescription on the computer screen. The tray and labelled medicines were then moved to a designated area for another pharmacist to conduct a further check.

The pharmacy team could access patient notes elsewhere in the hospital or contact the prescriber to resolve clinical queries such as interactions between medicines. Medicines were handed out to people by pharmacy students, pharmacists or pharmacy technicians who checked the ticket numbers to confirm identity. The pharmacy team members had 'open-bag' counselling policy so they provided counselling and an extra check on what was dispensed when handing out. The pharmacy maintained an electronic record of all prescription information and interventions along with the time and identity of the team members who prepared the prescription.

The pharmacy had standard operating procedures (SOPs) for the services it provided. And these had been recently reviewed and updated. Members of the pharmacy team were required to read the SOPs relevant to their roles and responsibilities. They knew what they could and could not do in the unlikely event that there was no pharmacist present. They would not hand out prescriptions or sell medicines. And they would refer repeated requests for the same or similar medicines which may be liable to misuse to a pharmacist. The pharmacy manager-maintained training records to show they understood the SOPs and would follow them. Members of the public could report a concern through the pharmacy's own complaints procedure via its head office and to Patient Advice and Liaison Service (PALS). People could also leave feedback about their visit to the pharmacy and the trainee pharmacists were required to obtain patient feedback as part of their training.

The pharmacy had risk assessed the impact of COVID-19 upon its services and the people who used it. The screens at the medicines counter remained in place to help improve infection control. The pharmacy manager described audits undertaken to monitor services such as waiting times for prescriptions, intervention logs, clinical systems and approval to supply medicines approved by the Trust medicines safety team. The pharmacy team were aware of new rules for dispensing valproates and new guidance which came into effect on 31 January 2024. New team members were required to work through the 'Safer Care' folder which included the new valproate guidance.

The pharmacy displayed a notice that told people who the RP was, and it kept a record to show which pharmacist was the RP and when. The pharmacy had appropriate insurance arrangements in place, including professional indemnity, for the services it provided. The pharmacy had a controlled drug (CD) register and the CDs were balance checked weekly. The actual stock of one CD matched the recorded amount in a random check. The pharmacy ordered specials or unlicensed medicinal products through the Trust procurement system which retained records of the orders. Their supply was recorded on EPIC. The pharmacy maintained paper records for cancer radio therapy and tramadol used by day-case non-resident patients having minor procedures. The pharmacy team monitored minimum and maximum temperatures for fridges where medicines were stored and detailed any reasons for temperature excursions.

The pharmacy reported any breaches of confidentiality to the Trust information governance (IG) team. It displayed a notice that told people how their personal information was gathered, used and shared by the pharmacy and its team. Its team tried to make sure people's personal information could not be seen by other people and was disposed of securely. The pharmacy had a safeguarding policy through the Trust and Lloyds head office. And all the team had to complete safeguarding training. Members of the pharmacy team knew what to do or who they would make aware if they had concerns about the safety of a child or a vulnerable person.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough team members who are qualified or training to have the appropriate skills and training for their roles. It supports learning and development. Members of the team work well together and manage their workload. The pharmacy team can provide feedback and concerns relating to the pharmacy's services.

Inspector's evidence

The pharmacy team consisted of four full-time pharmacists supported by relief pharmacists, two full-time and one part-time pharmacy technicians, four full-time and two part-time dispensing assistants, a part-time trainee dispensing assistant and two full-time medicines counter assistants. Members of the team were qualified or enrolled on accredited training in line with their roles. Two pharmacy students also accredited as dispensing assistants covered on Saturdays and during the week. Following a review of the workload, the pharmacy manager had changed the hours of some of the team to manage the work pattern more effectively over lunchtime.

Members of the team were allocated protected learning time to undertake training relevant to their roles and the pharmacy kept records to monitor progress and completed training. One of the pharmacy students was maintaining an EPIC training log sheet with a different section to evidence each skill being learned such as handing out a prescription. The pharmacy's head office provided ongoing training for team members via a training platform. The Trust provided mandatory training for the team such as 'health and safety' and safeguarding procedures.

Pharmacists had regular appraisals to review performance and identify learning activities to develop their skills. Reviews were more frequent to support people whose roles had changed. Safer care updates were discussed during regular team meetings or through the pharmacy's WhatsApp group. Team members worked well together managing the queue, serving people and processing prescriptions safely. The pharmacy manager was responsible for managing the pharmacy and its team. A pharmacist supervised and oversaw the supply of medicines and advice given to people. The pharmacy had a small range of over-the-counter (OTC) items for sale and team members at the medicines counter knew the questions they needed to ask people when making OTC recommendations and they knew when they should refer requests to a pharmacist. Members of the pharmacy team could make decisions to help keep people safe. They were comfortable about making suggestions on how to improve the pharmacy and its services. They could approach the pharmacy manager to raise a concern if necessary.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy's premises are bright, secure and suitable for the provision of healthcare services. People can have a private conversation with a team member in the consultation room. The pharmacy prevents people accessing its premises when it is closed so its medicines stock is safe, and people's private information is protected.

Inspector's evidence

The registered pharmacy premises were clean, bright and secure. The pharmacy had a large public area with seating for people who were waiting for their medicines. The medicines counter was on the left-hand side of the public area and the dispensary was beyond on the same level. The pharmacy had a consulting room where people were signposted if they wanted to have a private conversation with a team member. The dispensary had work benches which the team were constantly clearing to keep the environment tidy. The pharmacy kept records of when the pharmacy was cleaned.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy and its services are easily accessible to people. And it provides its services safely and effectively. People taking higher-risk medicines are provided with the information they need to use their medicines properly. The pharmacy obtains its medicines from reputable sources and manages them appropriately so that they are fit for purpose and 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.

Inspector's evidence

The pharmacy was well signposted and easy to find from the hospital entrance. It had a wide entrance which was level with the outside thoroughfare making it easier for someone who used a wheelchair to enter the premises. It had a notice that told people when it was open and a seating area set away from the counter for people to use if they wanted to wait. Members of the pharmacy team were helpful and they signposted people to another provider such as their regular doctor to continue treatment or to the hospital team if necessary. And they used a service which converted speech to text in different languages for people whose first language was not English.

The pharmacy team members had an ‘open-bag’ counselling policy so they provided an extra check of each item while counselling people on what was dispensed when handing out prescriptions. Only pharmacists, pharmacy technicians or pharmacy students handed out prescriptions. The pharmacy team members supplied warning cards with additional information for high-risk medicines, such as blue prednisolone cards and red hydrocortisone cards. They weighed children under 18 years of age to accurately calculate the dose of some medicines. They were aware of the new up-to-date guidance and rules for supplying valproate-containing medicines which must always be dispensed in the manufacturer's original full pack. And no-one under the age of 55 – both men and women - should be started on a valproate unless two specialists independently agree and document that there is no other safe and effective medication, or that there are compelling reasons why the reproductive risks linked to valproate, do not apply.

The pharmacy did not offer a delivery service for medicines but if necessary, the pharmacy team could arrange delivery of medicines via the hospital post room or by courier for items that required special conditions such as refrigeration. To manage stock levels of some medicines, the pharmacy kept enough stock to provide two weeks treatment and owe the remainder which the person could call back for or the pharmacy could deliver.

The pharmacy manager described the business continuity plan and back up system to deal with a failure of EPIC and still be able to provide pharmacy services. Risk assessments had been completed regarding pregnant staff members and potential harm from COVID infection.

Each team member had their own log in details identifying all the team members who prepared a prescription and the time of day creating an audit trail on EPIC. The pharmacy aimed to turn round each prescription within a certain time and audited waiting times for prescriptions to monitor the service and to help make sure waiting times remained within limit.

The pharmacy obtained its pharmaceutical stock through the Trust procurement department. And retail OTC stock through recognised wholesalers. It kept most of its medicines and medical devices in their original manufacturer's packaging. The pharmacy team checked the expiry dates of medicines and maintained records of when it was completed. The pharmacy stored its stock, which needed to be refrigerated, between two and eight degrees Celsius.
And it mostly stored its CDs securely in line with safe custody requirements. The pharmacy had procedures for handling the unwanted medicines people returned to it. And these medicines were kept separate from stock in pharmaceutical waste bins which were collected by arrangement with a licensed waste carrier. The pharmacy had a procedure for dealing with alerts and recalls about medicines and medical devices. And the pharmacy manager explained the actions they took and the records kept when the pharmacy received a concern about a product. The record linked to the responsible pharmacist record and who actioned and signed off the alert.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs for the services it offers. The pharmacy uses its equipment appropriately and keeps people's private information safe.

Inspector's evidence

The pharmacy had a plastic screen on its counter to help protect people from infections. In the event of a medical emergency the team could call the hospital ‘crash line’ to send the ‘crash cart’. The pharmacy team had access to up-to-date online reference sources and Trust guidelines. The pharmacy had fridges to store pharmaceutical stock requiring refrigeration. And its team regularly checked the maximum and minimum temperatures of each fridge to ensure the integrity of the medicines stock within. The pharmacy manager described how the team recorded and managed temperature excursions from the expected two to eight Celsius. The pharmacy had scales to weigh people taking high-risk medicines to make sure the dose was correct. The pharmacy collected and disposed of confidential waste appropriately. The pharmacy restricted access to its computers and PMR system. And only authorised team members could use them when they put in their password. The pharmacy positioned its computer screens so they could only be seen by a member of the pharmacy team.

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.