General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: PharmaC, Dispensary Level 7, The Clatterbridge Cancer Centre NHS Foundation Trust, 65 Pembroke Place, Liverpool, Merseyside, L7 8YA

Pharmacy reference: 9011348

Type of pharmacy: Hospital

Date of inspection: 09/06/2021

Pharmacy context

PharmaC is owned by The Clatterbridge Pharmacy Limited, which is a wholly owned subsidiary of the NHS Trust. Registered activities include the dispensing of prescriptions for inpatients and outpatients of the NHS Trust and other NHS Trust clinics, which are separate legal entities. The pharmacy dispenses approximately 12,000 prescription items each month and does not dispense FP10 or private prescriptions. The pharmacy opening hours are from 8.30am to 5.30pm on a Monday to Friday.

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	1.2	Good practice	The pharmacy records and analyses adverse dispensing incidents to identify learning points which are then incorporated into day to day practice to help manage future risk.
		1.7	Good practice	All members of the pharmacy team receive regular training and assessment to make sure they know how to protect confidential information.
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 generally manages the risks associated with its services and protects peoples' information. Members of the pharmacy team work to professional standards and are clear about their roles and responsibilities. They record their mistakes so that they can learn from them. And act to help stop the same sort of mistakes from happening again. The pharmacy keeps the records required by law.

Inspector's evidence

The pharmacy carried out risk assessments before the implementation of a new service and they had a risk register that covered all aspects of service provision. Clinical interventions were routinely recorded on the computer and the prescriber was contacted to discuss and clarify each intervention. All prescriptions were clinically checked by a pharmacist prior to being dispensed.

Near miss incidents were recorded on a log, reported on Datix, and were reviewed each month by a pharmacist or pharmacy team member, with a report being created to identify and trends or patterns. Detailed near miss records were provided. Dispensing errors were reported on an incident report form and any learning points were documented. The dispensing errors were reported to the superintendent (SI) pharmacist and the NHS Trust medicines safety officer, and they were discussed at the operational group meeting and monthly team meeting. Examples of how staff had learnt from near miss incidents or dispensing errors were provided by the pharmacy team. For example, different strengths of prednisolone stock had been separated. There were up to date Standard Operating Procedures (SOPs) for the services provided, with signature sheets showing that members of staff had read and accepted them. Roles and responsibilities of staff were set out in SOPs. A dispenser was seen to be following the respective SOPs for her role and she was able to clearly describe her duties. The staff were clear on their roles and responsibilities which were defined in the SOPs.

The pharmacy team members adhered to social distancing measures when possible. For example, they maintained a minimum of a two-metre distance from colleagues during the dispensing process. All team members wore personal protective equipment (PPE) throughout the day, which included a facial mask. And they had access to alcohol hand gel. The pharmacist had carried out covid-19 risk assessments for the pharmacy and for individual team members.

The pharmacy had a quarterly customer satisfaction survey carried out and the results from a recent survey were available. A dispenser described how she would deal with a patient complaint and said that she would refer to a pharmacist if necessary. The pharmacy team aimed to resolve all complaints in the pharmacy in accordance with the complaints procedure. A current employer's liability and professional indemnity insurance certificate was displayed. The responsible pharmacist (RP) record, specials procurement record and CD register were in order. CD running balances were kept and were regularly audited. A comprehensive CD audit was carried out annually, with a copy of the previous audit available.

The pharmacy completed the information governance (IG) toolkit annually. It had confidential waste bins that were removed by an authorised carrier when necessary. The pharmacy team members had signed a confidentiality agreement as part of their employment conditions. The pharmacy team received mandatory information governance training on an annual basis and the record of training was

provided. Computers were password protected. The pharmacy team members completed safeguarding level 2 training for children and vulnerable adults on an annual basis, and the pharmacists had also completed safeguarding level 3 training. Up to date contact details for reporting a safeguarding concern were present.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough team members to manage its workload safely. The team members are trained and work effectively together. They are comfortable about providing feedback to their manager and receive feedback about their own performance to help them improve. The pharmacy enables its team members to act on their own initiative and use their professional judgement, to the benefit of people who use the pharmacy's services.

Inspector's evidence

There were three pharmacists, including, SI, deputy SI and a locum who was the responsible pharmacist (RP), three accuracy checking pharmacy technicians (ACPT), one pharmacy technician and nine dispensers on duty in the pharmacy. The pharmacy had two team members on annual leave and was operating at its usual staffing level.

The pharmacy had a formal appraisal process for team members, carried out annually by the management team. The pharmacy had detailed training records for all staff, that included signed competencies for their role and evidence of mandatory training for the NHS Trust. New starters were expected to complete a training log which contained a detailed weekly log of activities they had carried out over a 12-week period. The pharmacy team members explained that adequate time for training was provided on an ongoing basis in work. A dispenser said that both the SI and deputy SI were supportive of training and approachable if she needed to ask questions or had queries.

The pharmacy held regular team briefings, where dispensing errors or near miss incidents were openly discussed. The pharmacy team were aware of the staffing structure and a dispenser explained that she would bring any concerns to the attention of SI or their deputy. The pharmacy team had no formal targets or incentives set.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean and tidy. It is a suitable place to provide healthcare. And it has adequate facilities for team members.

Inspector's evidence

The pharmacy was clean and professional in appearance. The pharmacy team were responsible for the cleaning in the pharmacy. Dispensary benches and sink were cleaned regularly, and a cleaning rota was present. A contract cleaner for the NHS trust cleaned the floor and emptied the waste bins on a regular basis. The temperature in the pharmacy was controlled by air conditioning / heating units. Lighting was excellent. Maintenance problems were reported to the NHS Trusts maintenance department. The pharmacy team members facilities included a staff room and WC's with wash hand basins and antibacterial hand wash.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's services are accessible to some people and they are generally managed, so people receive their medicines safely. The pharmacy takes extra care when supplying some higher-risk medicines. It sources and stores medicines safely and carries out some checks to help make sure that medicines are in good condition and suitable to supply.

Inspector's evidence

The pharmacy was not directly accessible to patients and the public. Dispensed prescriptions to be collected by patients were sent directly via an internal goods lift to their other pharmacy on level M1 of the hospital. Staff were clear about what services were offered and where to signpost to a service if this was not provided. The pharmacy's workflow was organised into separate areas for dispensing different types of prescription and there was a checking area for the pharmacist and ACPT. Dispensed by and checked by boxes were initialled on the medication labels to provide an audit trail. Baskets were used in the dispensary to reduce risk of medicines becoming mixed up. Various stickers including, CD, fridge and see pharmacist were attached to assembled prescriptions awaiting collection if necessary. For example, a see pharmacist sticker had been attached to an assembled prescription, to ensure the pharmacist provided counselling for a reducing dose of oral steroids. The pharmacy team were aware of the risks associated with the use of valproate during pregnancy, and they had patient information resources to supply with valproate if needed. The deputy SI explained that patients prescribed Thalidomide received counselling, which was recorded online, and that the pharmacy team were aware of the associated pregnancy prevention scheme.

The deputy SI explained that some patients were prescribed complex regimes and or high-risk medicines such as oral chemotherapy and reducing doses of oral steroids. She explained that when prescriptions were received in the pharmacy for patients prescribed oral chemotherapy, the patients' weight, allergy status and blood tests must be up to date and available for the pharmacist to check. She demonstrated on a patient's clinical record that they had up to date blood test results, that were within the defined range, to allow their prescription to be supplied.

The SI and deputy SI demonstrated how prescriptions were processed. Approximately 75% of the total prescriptions dispensed were supplied to "network" patients who were seen in other NHS trust clinics across the north west region. The other 25% of prescriptions were supplied to inpatients or outpatients of the NHS trust. The dispensing labels for the prescriptions of the network patients were produced in the hospital pharmacy's prescription verification room by a dispenser employed by the pharmacy. The room was situated on the same floor of the pharmacy, and outside of the registered area. The dispensing labels for the inpatient and outpatient prescriptions of the NHS trust were produced in the pharmacy. The clinical check of the network patient prescriptions was carried out by hospital pharmacists and the dispensing labels were cross checked for accuracy against the prescription at this point. Whereas, the clinical check of all inpatient and outpatient prescriptions for the NHS trust was carried out by a pharmacist, in the pharmacy, prior to dispensing. Once the network prescriptions had been clinically checked and the dispensing labels had been cross checked by a hospital pharmacist, the dispensing labels were placed in baskets and sent through to the pharmacy for assembly, but the prescription itself remained in the hospital pharmacy's prescription verification room. The dispensing labels were attached to the medicine container in the pharmacy and an ACPT or pharmacist carried out

an accuracy check against the dispensing label and medicine. This meant the responsible pharmacist had no sight of the prescription during the clinical or accuracy checking process, which may blur the lines of accountability and responsibility for the supply of network prescription medicines and may increase the possibility of error.

The date of opening was written on stock bottles of liquid medicines with limited shelf life. CDs were stored appropriately. Date checking was carried out and documented on a matrix. Short dated medicines were highlighted with a sticker attached to the medicine box. Several medicines were sampled and no out of date medicines were present. Drug alerts and product recalls were received via e-mail. These were read and acted on by the pharmacist or pharmacy team member and filed in the pharmacy.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide services safely. It is used in a way that protects privacy. And the electrical equipment is regularly tested for safety purposes.

Inspector's evidence

The pharmacy team used the internet to access websites for the most up to date information. For example, patient information leaflets. Copies of the BNF and BNFc were present. There were seven clean fridges for medicines storage with internal and external thermometers. The minimum and maximum temperatures were being recorded daily, were in range at the time and the records were complete.

The pharmacy team reported any problems with equipment to the SI or deputy SI. The electrical equipment all appeared to be in working order and had been PAT tested. There was a selection of liquid measures with British Standard and crown marks. The pharmacy had triangles for counting loose tablets and capsules and a designated triangle for cytotoxic medicines. Computers were password protected. The pharmacy had a cordless telephone available and this was used for private conversation with patients if required.

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.