General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Lloydspharmacy, Outpatients Pharmacy, Queen Alexandra Hospital, Southwick Hill Road, Cosham, Portsmouth, Hampshire, PO6 3LY

Pharmacy reference: 9011713

Type of pharmacy: Hospital

Date of inspection: 01/03/2022

Pharmacy context

This pharmacy is just inside the north entrance of Queen Alexandra Hospital, on the northern outskirts of Portsmouth. It only dispenses prescriptions written in the hospital for people who aren't staying there. So, it can't dispense any prescriptions that people might bring in from their GP. It sells over-the-counter (OTC) medicines and some other health-related products.

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 team can show that it has learned from things going wrong and made changes to prevent them happening again. They share their learnings and learn from other clinicians within the hospital and also with other branches of the company.
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	4.2	Good practice	All prescriptions are rigorously checked against numerous clinical reference sources to ensure that they are correct. Any queries are confirmed directly with the hospital clinician involved and medicines only supplied once resolved. All patients are counselled in detail about their medicines to help ensure they take them safely
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance ✔ Standards met

Summary findings

The pharmacy provides its service in line with very clear, up-to-date procedures which are being closely followed by its team members. They are clear about their roles and responsibilities. And they work to high professional standards, identifying and managing risks very effectively. The pharmacists work well with other clinical professionals in the hospital to make sure that the service they provide is safe. The pharmacy keeps good records of the mistakes that happen during the dispensing process. The pharmacist manager regularly reviews them with members of the team so that they can learn from them and avoid problems being repeated. The pharmacy manages and protects confidential information well and its team members understand their role in helping to protect the welfare of vulnerable people. The pharmacy has suitable insurance in place to help protect people if things do go wrong.

Inspector's evidence

There were standard operating procedures (SOPs) in place to underpin all professional standards dated 20 September 2021. They had been developed specifically for this pharmacy's outpatient dispensing services. There was a signature sheet, signed by all staff between November 2021 and January 2022 to indicate that they had read and understood those SOPs which were appropriate for their roles. The pharmacy's team members had worked very closely with the main hospital pharmacy department to ensure that they understood the key differences between dispensing prescriptions here and in a 'normal' community pharmacy. In the event of any problems, they could work together with the hospital pharmacy to ensure that people continued to receive their services. There was an 'outpatient dispensary professional standards audit' questionnaire which had been completed showing that the pharmacy complied with the hospital's professional requirements.

Errors and near misses were recorded to show possible causes and to provide evidence of reflection and learning. There was a near miss record sheet by the responsible pharmacist's (RP) workstation which was completed every day. So, if there had been no near misses on any particular day, this was noted on the record. Staff were seen making their own entries on the near miss record as soon as the pharmacist had identified them. Completed sheets were kept in a separate file, together with other completed documents. The RP (who was also the pharmacy's manager) explained that they didn't see the same types of near misses or errors that might typically occur in a 'normal' community pharmacy. Many of the items that might have been considered to be prone to errors were not stocked in this pharmacy. They did find that some of the more unusual injections could be mixed up, so they had added 'double check!' warning prompts to their computer system as well as highlighting the prescription when initially screening it. They knew that they had to take extra care when checking the dosage of each medicine, which would then also determine the quantity to be supplied. Any errors that left the pharmacy were recorded on the hospital's 'Datix' system as well as the company's own 'PIMS' system. These records also included any actions taken as a result of the errors, and what they had learned from it. Most of the early errors were as a result of the pharmacy not having the required items in stock. Despite having taken advice from the hospital pharmacy department about their opening stocks, they soon found that they needed to keep more stock of some products that they hadn't anticipated. According to the RP, things had settled down now and they generally had the necessary items in stock, including a number of unlicensed 'specials' which were frequently prescribed. The near

misses and errors were reviewed each week and the RP highlighted the key learnings to the team. One of the dispensing assistants was the 'safer care' champion, and she kept a record of these reviews in the 'safer care' file. The 'safer care' file had records of all the weekly checks made over a twelve-week cycle. Every Wednesday the 'safer care' champion had a 'safer care' conference call with a number of other pharmacies within the company to share their learnings and improve.

The RP explained how they were making many more prescription interventions as well. If there were any discrepancies in the prescription, they would not dispense it until they had spoken to the prescriber and confirmed their intentions. A typical example might be if the person's weight had not been recorded on the prescription, as this was needed for calculating the correct dose. There was a spreadsheet where they kept a record of every intervention. The spreadsheet showed graphs of the types of intervention and the trends. The RP shared this information with other departments within the hospital to help improve their prescribing.

There were records of competence for each member of staff, showing which tasks they were able to complete, clarifying their roles and responsibilities. Those questioned were able to clearly explain what they do, what they were responsible for and when they might seek help. The responsible pharmacist notice was clearly displayed for people to see. Details of every pharmacist on duty each day, including the RP, were recorded on one of the pharmacy's computers. Those records examined were complete. A certificate of professional indemnity and public liability insurance from the National Pharmacy Association (NPA) valid until 30 June 2022 was on display.

The controlled drugs (CD) register was seen to be correctly maintained, with running balances checked at regular weekly intervals. Running balances of two randomly selected CDs were checked and both found to be correct. Alterations made in the CD register were asterisked with a note made at the bottom of the page, and they were initialled with the pharmacist's name, registration number and date.

There were summary sheets recording all of the unlicensed 'specials' obtained and supplied by the pharmacy. The record sheets were based on those used by the main hospital pharmacy and included space for a copy of the dispensing label, details of the prescriber, the manufacturer and whether the pharmacy had received a certificate of conformity (CoC) or a certificate of analysis (CoA). The records didn't all include the prescriber details as they weren't always obvious from the prescription. The RP explained that she would normally add the hospital department if she couldn't identify the individual prescriber. The CoCs and CoAs themselves were stored separately, together with the pharmacy's invoices and other records.

Completed prescriptions in the prescription retrieval system were out of public view in the dispensary. Confidential waste was kept separate from general waste in designated sacks under each workstation and removed for shredding by a hospital contractor. One of the dispensing assistants was responsible for ensuring that the necessary documentation was sent to the appropriate department in the hospital each week so that the sealed sacks would be collected.

There were safeguarding procedures in place and all registrants had completed level two safeguarding training. The rest of the team had either completed Lloyds training in their previous branches, or had undergone similar training in their previous employment.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough staff, with a wide variety of skills, to manage its workload safely. Pharmacy team members are well-trained and have a clear understanding of how their roles and responsibilities fit in with working in a hospital. They work well together as a team and can make suggestions to improve safety and workflows as required.

Inspector's evidence

There were four fully-trained dispensing assistants, one trainee dispensing assistant, two fully-trained medicines counter assistants (MCA), one registered pharmacy technician and two pharmacists (including the RP) on duty during the inspection. This appeared to be appropriate for the workload and they were working well together.

Training records were not examined as most team members had completed their accredited training in other branches of the company. The RP described how she and members of her team had spent a month being trained by the main hospital pharmacy team before their pharmacy opened. This was mainly because the hospital work involved much more clinical input than they may have previously been accustomed to in the community. The trainee dispensing assistant described her paper-based training programme. This included modules for working at the medicines counter as well as for dispensing. She had completed several modules and appeared to be happy with her progress. The registered pharmacy technician had been accredited as an accuracy checker in his previous employment. He would soon be going through a reaccreditation programme owing to the significant differences in the nature of the prescriptions to be checked. One of the dispensing assistants confirmed that the company did provide them with ongoing training materials to help them keep up to date. Individual risk assessments associated with the pandemic had been carried out for staff, and all were wearing masks.

Both MCAs were seen serving people and asking appropriate questions when responding to requests or selling medicines. One of the dispensing assistants was also working at the medicines counter to provide people with much more detailed information about their medicines. The RP described how they always had either a pharmacist or a dispensing assistant at the counter so that they could explain more about people’s medicines and help improve their understanding.

There were currently no targets in place, but the RP indicated that they would shortly be given targets by the hospital. Those targets would focus on waiting times, owings and complaints. The waiting times were monitored on a display screen so that people could see when their prescription would be ready. ‘WOW!’ review forms were given to people when they received their prescriptions, so that they could provide feedback on the pharmacy’s service. Completed ‘WOW!’ reviews were kept in a file with the other documents referred to earlier. There was a relaxed but professional atmosphere within the pharmacy and team members seemed able to speak freely about their mistakes and learning from them.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy's premises are welcoming and provide a suitably professional setting for the service it delivers. They are bright, clean and easily accessible to people using the hospital. The pharmacy has considered the effects of the COVID-19 pandemic and takes suitable precautions to help minimise its spread.

Inspector's evidence

The registered pharmacy premises were near the north entrance of the hospital. They were well signposted and had wide open entrances from the main hospital corridor. There were no steps and people had plenty of space in which to wait. They were very clean and tidy with no visible clutter. The dispensary was separated from the retail area by a full height wall behind the medicines counter and prescription reception or handout areas. There were Perspex screens along the full length of the counter to help reduce the spread of the coronavirus.

The dispensary was very large, with workstations along each wall and on two central islands. There was an area towards the rear that was used as a rest area for the staff. The sink was kept very clean as the RP insisted on it being tidied up every time it was used. There was hot and cold running water with sanitiser for handwashing. There was plenty of space for the team to work safely and effectively, and the layout was suitable for the activities undertaken. There was a clear workflow in the dispensary.

Staff were able to use the hospital toilet facilities, which were not included in the inspection. Room temperatures were appropriately maintained by the hospital air-conditioning, keeping staff comfortable and suitable for the storage of medicines.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy delivers its service in a safe and effective manner, providing people with plenty of detailed advice about their medicines. It identifies people supplied with high-risk medicines, or those who need regular checks, so that they can be given extra information to help them take their medicines safely. It makes sensible adjustments to its procedures, taking into account the varying needs of the different hospital departments and the people attending their clinics. The pharmacy sources, stores and manages its medicines safely, and so makes sure that all the medicines it supplies are fit for purpose. It responds well to drug alerts or product recalls to make sure that people only get medicines or devices which are safe for them to take.

Inspector's evidence

The pharmacy only dispensed outpatient prescriptions written by prescribers within the hospital. The RP showed how these prescriptions differed from those normally seen in community pharmacies. They annotated every prescription to show which pharmacist had screened the prescription, which dispensing assistant had labelled and assembled it, who checked it for accuracy and finally who handed it out. The final check was not completed by the same pharmacist who had initially screened the prescription. That initial screening involved a thorough clinical check of each medicine using a number of clinical reference sources. There was a file containing the hospital's prescribing protocols, which the pharmacist used to help them check the dose against a number of relevant factors such as the person's weight and age. Those protocols included how unlicensed medicines could be prescribed for children.

There were controls in place to help reduce the risk of selection errors, such as the use of A4-sized trays to keep individual prescriptions separate. Prescription labels were initialled to show who had dispensed and checked them. Owings tickets were being used and prescriptions were kept in the owings file until the stock arrived. The RP explained that many people came to the hospital from a long way away, so owings tended to remain uncollected for much longer than expected. Now that they understood this, the team did not return uncollected prescriptions or owings back into stock as soon as they did initially. They also liaised with the different hospital departments, such as oncology or respiratory, as the different departments often reviewed people's medicines at different time intervals. This had a knock-on impact upon the collection of their prescriptions. The RP did however confirm that they did not hand out any controlled drugs (CDs) more than 28 days after the date of prescribing. The prescription retrieval shelves were cleared of uncollected items over six weeks old, only after having checked with the relevant consultant first. There were several items on the shelf dating back more than six weeks because the RP still expected them to be collected.

The second pharmacist confirmed that he was aware of the risks involved in dispensing valproates to females in the at-risk group. He did indicate that they didn't see very many prescriptions for valproates but would check if people were aware of the risks associated with them and advise them accordingly. Prescriptions for some other high-risk medicines, or those requiring regular monitoring such as methotrexate would only be dispensed in part, so that people had to attend their review or have a blood test before collecting the remainder. The pharmacy had access to all the blood test results so that they could make sure the dose was either still correct or had been suitably adjusted. Prescriptions from the respiratory department tended to be for six months at a time, so for the reasons described above, the pharmacy only supplied them one month at a time. If there were any queries regarding the

prescription or blood test results, the pharmacy would not supply the medicine until the query had been resolved with the prescriber.

Prescription medicines were obtained from the hospital's main supplier, the Regional Drug Procurement centre (RDP) and OTC medicines from AAH. CDs were signed for separately to show who had received them, and those signature sheets were kept in a file for future reference if needed. There were four fridges and one freezer, each with its own temperature record. Those records examined were all found to be in order and within the correct temperature range. Upon questioning, one of the dispensing assistants showed that she knew what to do if a fridge temperature measurement fell outside of the required range.

The RP demonstrated the screening process for patient-returned medicines, whereby any medicine bags were emptied into a tray so that items could be segregated if necessary. People returning injections or other sharps were appropriately signposted elsewhere for disposal. The pharmacist was informed of any CDs so that they could be recorded and denatured before being disposed of safely. Appropriate record books were seen and appeared to be in order. The pharmacy had some denaturing kits available for returned CDs. The returned medicines were stored in designated waste containers kept in a secure cupboard away from usable stock. There was a separate container for hazardous waste. The waste containers were full and the dispensing assistant responsible for arranging the waste collections explained the difficulties they were currently experiencing with arranging their disposal. It had taken longer than expected for the pharmacy to be added to the hospital's system for collecting pharmaceutical waste, but this was now complete. The hospital's waste contractor was due to collect their unwanted medicines for destruction every other Thursday.

The pharmacy received drug alerts and recalls from the MHRA via the company's head office, copies of which were kept in a file together with a summary sheet detailing any action taken, who by and when. There were also record sheets signed to confirm when recalled items had been retrieved from individual people.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has adequate facilities for the services it provides, and it makes sure that they are correctly used. It also ensures that people's private information is kept safe and secure.

Inspector's evidence

The pharmacy had the access to multiple clinical reference sources which were critical to the service it was providing. It had a range of crown stamped measuring flasks and counting triangles (including a separate clearly labelled triangle for cytotoxics such as methotrexate). The pharmacy kept a stock of sterile water for use when reconstituting antibiotics as it did not use tap water for dispensing. The pharmacy also had online access to the same systems as the hospital's main pharmacy.

There were Perspex screens in place along the medicine counter to help reduce the transmission of the virus. Every member of the team was wearing a mask, as were people waiting to collect their prescriptions. There was a supply of free masks for people to use when they entered the hospital.

Access to the various computer systems was controlled through individual passwords, and none of their screens were visible to the public. Confidential information was kept secure and items awaiting collection were not visible from retail area.

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.