General Pharmaceutical Council

# Registered pharmacy inspection report

**Pharmacy Name:** Woodlands Chemist, 1 Bishopscote Road, LUTON, Bedfordshire, LU3 1NX

**Pharmacy reference:** 1028847

**Type of pharmacy:** Community

**Date of inspection:** 20/11/2019

## Pharmacy context

The pharmacy is located near a doctor's surgery in a mainly residential area in Luton. It dispenses NHS and private prescriptions, sells over-the-counter medicines and provides health advice. The pharmacy dispenses medicines in multi-compartment compliance aids for people who have difficulty managing their medicines. Services include prescription collection and delivery, substance misuse, emergency hormonal contraception, weight management, travel medicines and vaccinations and seasonal flu vaccination. The pharmacy has healthy living status.

## 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 | 1.1 | Good practice | The pharmacy actively identifies and manages the risks associated with provision of its services. |
| **2. Staff** | Standards met | 2.2 | Good practice | Staff learning and development is supported. |
| | | 2.5 | Good practice | Staff feedback is encouraged and acted upon to improve services. |
| **3. Premises** | Standards met | N/A | N/A | N/A |
| **4. Services, including medicines management** | Standards met | 4.1 | Good practice | People with a range of needs can access the pharmacy's services. |
| | | 4.2 | Good practice | Pharmacy services are managed and delivered safely and effectively. |
| **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. The pharmacy team makes sure that people have the information they need so that they can use their medicines safely. The pharmacy manages risk well and it has written procedures which tell staff how to complete tasks effectively. It generally keeps the records it needs to so that medicines are supplied safely and legally. The pharmacy team keeps people's information safe and understands its role in protecting vulnerable people.

### Inspector's evidence

Near misses were recorded, reviewed and actions taken to prevent a repeat near miss were shared with the pharmacy team. Monthly patient safety reviews (PSR) were completed and key learning points included twice daily deliveries which reduced owing or outstanding medication and improved stock management. Improved stock management of medicines on the dispensary shelves had resulted in fewer picking errors. During the dispensing process, dispensed medicines were re-checked by the dispensers prior to the pharmacist's final check.

To minimise picking errors, the location of medicines had been re-arranged A-Z. Empty white dispensing cartons endorsed 'CARE' were placed on the dispensary shelves to alert staff to select medicines with care such as prednisolone and pioglitazone which were available in more than one strength or form. Different strengths and forms of metformin were highlighted by 'CARE' shelf edge labels and different strengths of co-codamol were separated. The pharmacy team had completed 'Lookalike, soundalike' (LASA) medicines training and there was a LASA list of medicines on display. In line with the Pharmacy Quality Scheme (PQS), co-codamol 8/500, co-codamol 30/500 and co-dydramol had been risk assessed and placed on a new separate shelf to reduce errors and improve patient safety.

Workflow: baskets were in use to separate prescriptions and medicines during the dispensing process. Labels were generated, and medicines were picked from reading the prescription. There were separate dispensing and checking areas. The pharmacist performed the final check of all prescriptions prior to completing the dispensing audit trail to identify who dispensed and checked medicines. Interactions between different medicines for the same patient were shown to the pharmacist. There was a procedure for dealing with outstanding medication. The original prescription was retained, and an owing slip was issued to the patient. For 'manufacturer cannot supply' items the patient was asked how urgently they required the medication and the doctor was contacted to arrange an alternative if necessary.

Multi-compartment compliance aids were prepared for a number of patients. The pharmacy managed prescription re-ordering on behalf of some patients. The pharmacy liaised with the prescriber when a new patient was identified who would manage taking their medicines more effectively via a compliance aid. There was a folder of patient records including sample backing sheets. Re-printing backing sheets rather than over-writing was discussed to ensure changes in medication were clear. A description to identify individual medicines was supplied and patient information leaflets (PILs) were supplied with each set of compliance aids. Compliance aids were re-dispensed when there were changes in medication.

High-risk medicines such as alendronate were generally supplied separately from the compliance aid.

The dates of controlled drug (CD) prescriptions were managed to ensure supply within the 28-day validity of the prescription. Levothyroxine and lansoprazole were sometimes supplied in the compliance aid to ensure they were consumed by the patient. Checking stability was discussed if sodium valproate was to be supplied in a compliance aid.

The practice leaflet was on display and included details of how to comment or complain. The annual patient questionnaire was being conducted at the time of the visit. The standard operating procedures (SOPs) were due for review at the time of the visit although staff training records were up to date. The staff member who served at the medicines counter said she would not give out a prescription or sell a P medicine if the pharmacist were not on the premises.

To protect patients receiving services, there was professional indemnity insurance in place provided by NPA expiring 31 Dec 2019. The responsible pharmacist notice was on display and the responsible pharmacist log was completed. Records for private prescriptions, emergency and 'specials' or unlicensed medicines supplies were generally complete. A sample of patient group directions (PGDs) examined were in date and signed.

The CD and methadone registers were mostly complete, and the balance of CDs was audited although more regular balance checks were discussed. A random check of the actual stock of two strengths of MST reconciled with the recorded balance in the CD registers. Footnotes correcting entries were signed and dated. FP10MDA prescriptions were endorsed at the time of supply. Invoice number and supplier name but not address were recorded for receipt of CDs. Patient returned CDs destruction was recorded in the private prescription register.

Staff had signed confidentiality agreements and were aware of procedures regarding General Data Protection Regulation (GDPR). Information on 'Your data matters to the NHS' was displayed. The Data Security and Protection toolkit had been completed. There was a shredder to deal with confidential waste paper and a cordless phone to enable a private conversation. Staff used their own NHS cards. The pharmacy computer was password protected and backed up regularly. Staff had undertaken dementia friends and safeguarding training and the pharmacist was accredited at level 2 in safeguarding training. Contact details to report concerns were displayed in the pharmacy.

## Principle 2 - Staffing ✔ Standards met

### Summary findings

The pharmacy has enough properly trained staff to manage its workload and deliver its services safely. They are comfortable about providing feedback to the pharmacist and are involved in improving the pharmacy's services.

### Inspector's evidence

Staff comprised: one regular full-time pharmacist, one full-time pre-registration pharmacist, one part-time dispenser also accredited as a medicines counter assistant (MCA), one part-time dispenser also accredited as MCA and who was an apprentice customer assistant through a local college, and two part-time MCAs (one enrolled and one accredited). Dispensing and MCA training was via the NPA.

The pre-registration pharmacist had protected learning time and was enrolled on the NPA pre-registration training programme and the pharmacist was his pre-registration tutor. The NPA provided monthly training days and topics included diabetes, gastro-intestinal, cardio-vascular, emergency hormonal contraception (EHC) and calculation. There were 13 weekly appraisals to monitor progress and an objective to improve time management had been set. The pharmacist said the pre-registration pharmacist had an action plan of training which included safeguarding.

There were training sessions during lunchtimes and a WhatsApp group to communicate with staff members. Training included stock management and preventing overdose by asking WWHAM questions. To meet PQS requirements the pharmacist had attended a Centre for Pharmacy Postgraduate Education (CPPE) workshop on Community Pharmacist Consultation Service (CPCS). Following the visit, the pharmacist confirmed that the pharmacy was now live for CPCS and checking PharmOutcomes for referrals twice daily. At the time of the visit, training was in progress in sepsis, LASA errors, safeguarding and risk management. Staff felt able to provide feedback and had suggested reviewing the retrieval system for prescriptions awaiting collection. Bagged prescriptions were stored in numbered boxes and the prescription was endorsed with the same number but filed alphabetically by name for ease of location when people came to collect their medicines. They had also suggested twice daily deliveries by the wholesalers to reduce the size of delivery and reduce the workload of putting away the medicines. The pharmacist said targets and incentives were not set in a way that affected patient safety or wellbeing.

## Principle 3 - Premises ✔ Standards met

### Summary findings

The pharmacy's premises are clean and suitable for the provision of its services. The pharmacy prevents people accessing the premises when it is closed to keep medicines and information safe.

### Inspector's evidence

The pharmacy was located on a corner site at the junction of two roads. The medicines counter was located to the right-hand side of pharmacy and was 'L' shaped. Fixtures and fittings were older in style. The dispensary was at the back of the pharmacy premises and at a slightly lower level than the public retail area. The consultation room was positioned at the end of the medicines counter and at the back of the retail area. It was locked when not in use. The consultation room was a little untidy. There was a poster regarding dealing with anaphylaxis in connection with vaccination services. The pharmacy premises were generally clean and tidy. Lavatory facilities were clean and handwashing equipment was provided. There was sufficient lighting and ventilation. Fans were available for use in warmer weather.

## Principle 4 - Services ✔ Standards met

### Summary findings

People with a range of needs can access the pharmacy's services. The pharmacy provides its services safely and effectively and it gets its medicines from reputable sources to protect people from harm. It makes sure that medicines are stored securely at the correct temperature so that medicines supplied are safe to use. The pharmacy team know what to do if any medicines or devices need to be returned to the suppliers. They give advice to people about where they can get other support and make sure that people have all the information they need so that they can use their medicines safely.

### Inspector's evidence

There was a ramp and bell at the entrance and staff went to the door to assist people with mobility issues. Large font labels could be printed to assist visually impaired people. Staff could converse in Urdu, Hebrew and Hindi to assist patients whose first language was not English. Notes were written to assist hearing impaired people. Patients were signposted to other local services including dentist, NHS 111 and out of hours services. Signposting events were recorded on the patient medication record (PMR) if possible. People could access a number of services via PGDs including erectile dysfunction (ED), EHC, hair loss treatment, weight management, norethisterone for period delay, hay fever, travel medicines (malaria prophylaxis and vaccinations) and flu vaccination. Pregnancy testing was available.

The pharmacist explained the procedure for supply of sodium valproate to people in the at-risk group. Information on the pregnancy prevention programme (PPP) was explained to at-risk people. An alert regarding sodium valproate and PPP was flagged on the pharmacy computer when entering prescriptions. An intervention was recorded on the patient medication record (PMR). The pharmacist explained the procedure for supply of isotretinoin to people in the at-risk group. Isotretinoin should be prescribed by a specialist and supplied within seven days following a negative pregnancy test. The prescriber would be contacted regarding prescriptions for more than 30 days' supply of a CD. CD prescriptions were highlighted with a warning sticker, and the date checked to ensure supply within the 28-day validity period. Interventions were recorded on the PMR.

A counselling log was maintained and prescriptions for high-risk medicines such as sodium valproate, lithium, CDs and fridge items were highlighted with warning stickers. The pharmacist said when supplying warfarin, people were asked for their record of INR along with blood test due dates. The INR was recorded on the PMR. Side effects of bruising and bleeding were explained. Advice was given about over-the-counter medicines and diet containing green vegetables and cranberries which could affect INR. People taking methotrexate were reminded to have regular blood tests, about the weekly dose and when to take folic acid. People were advised to seek medical advice if they developed an unexplained fever. Information sources such as methotrexate purple book were available to give to patients.

An audit had been conducted to identify people for referral for prescription of a proton pump inhibitor for gastric protection while taking a non-steroidal anti-inflammatory drug (NSAID). The audits regarding prescription of salbutamol with no steroid inhaler for six months and acute kidney injury had been conducted (reported on PharmOutcomes). At the time of the visit there were planned audits of dates of last foot checks and retinopathy screening for diabetic people and identifying people taking combination anti-platelet therapy more than one year after starting the therapy. There were health

related leaflets for members of the public to raise awareness of conditions including Stoptober, alcohol awareness and sepsis. Health campaigns had included carbon monoxide monitoring during Stoptober to encourage people to quit. Public awareness of sepsis and flu vaccination had been promoted.

Medicines and medical devices were delivered outside the pharmacy mainly by the pharmacist. A drop sheet was prepared with bag labels which were each numbered. Upon successful delivery the patient was asked to sign a numbered square on the reverse of the drop sheet. The number on the square corresponded to the number on their bag label. Patient private details were protected from view on the front side of the drop sheet where bag labels of the delivery patients were attached.

Medicines and medical devices were obtained from Alliance, AAH, Sigma, NWOS and DE South. Floor areas were clear, and stock was neatly stored on the dispensary shelves. Stock was date checked and recorded. No date-expired medicines were found in a random check. Liquid medicines were marked with the date of opening and medicines were stored in original manufacturer's packaging. Cold chain items were stored in the medical fridge. Uncollected prescriptions were cleared from retrieval monthly and patients were contacted depending on the type of medication. Waste medicines were stored separately from other stock. Falsified medicines directive (FMD) hardware and software was not fully operational at the time of the visit. Drug alerts were received, actioned and filed.

## 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 and facilities appropriately to keep people's private information safe.

### Inspector's evidence

Current reference sources included BNF, eBNF, Guidelines (clinical) for Pharmacy + the Ap, Patient.co.UK and Fit for Travel. The dispensary sink was generally clean and there were standard glass measures including separate marked measures for methadone. The medical fridge was in good working order. Minimum and maximum temperatures were monitored daily and found to be within range two to eight Celsius. The CD cabinets were fixed with bolts. The stop smoking service carbon monoxide meter was supplied and maintained by Turning Point. The blood pressure monitor was not due for recalibration. The sharps bin for vaccination sharps disposal was in the locked consultation room. There were three in date adrenaline injection devices the pharmacist in case of anaphylaxis during vaccination. There was a shredder to deal with confidential waste paper and a cordless phone to enable a private conversation. Staff used their own NHS cards. The pharmacy computer was password protected and backed up regularly.

## 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. |