General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Greencross Pharmacy, 1 Allen Street, WARRINGTON, Cheshire, WA2 7JD

Pharmacy reference: 1029804

Type of pharmacy: Community

Date of inspection: 09/10/2019

Pharmacy context

The pharmacy is on a main road on the outskirts of town, close to a medical centre. It dispenses NHS and private prescriptions and sells a range of over-the-counter medicines. It supplies medicines in multi-compartment compliance packs. And delivers medicines to people at home. The pharmacy provides a range of services. These include blood pressure checks and emergency hormonal contraceptive (EHC) supply; The pharmacy provides seasonal flu vaccinations. People can access the NHS Urgent Medicine Supply Advanced service (NUMSAS) from the pharmacy, with referrals from NHS111.

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 team members consistently record near miss errors each month. And they openly discuss the causes of these errors and the contributing factors. So, they can share their learning and make effective changes to reduce the risks of future mistakes.
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 identifies and manages the risks with its services. And it has up-to-date written procedures for the team to follow, to help deliver its services safely. The team members record and openly discuss the causes of mistakes that happen whilst dispensing. So, they can share their learning and make effective changes to reduce the risks of future mistakes. The team members know their role in protecting the welfare of children and vulnerable adults. And they have the experience to recognise when they need to raise a concern. The team members mostly make the records they must by law and they keep people's private information secure.

Inspector's evidence

The pharmacy was open plan with the shop and dispensary all in one space. The pharmacy counter with shelving either side prevented access into the dispensary. And the shelving was high enough to ensure people couldn't see over into the dispensary. The team was aware that conversations could be overheard. And spoke softly to each other when discussing prescriptions and workload. During the inspection it was rare for more than person to be in the shop. So, the team could mostly speak freely with people about their medicines. And the pharmacy had a consultation room if needed, which people could access from the retail area. There were two areas to the dispensary either side of the pharmacy counter. This allowed the pharmacy to dispense multi-compartment compliance packs on a separate bench. The pharmacy had a stock room and toilet facilities also accessed off the retail area.

The pharmacy had a set of up-to-date standard operating procedures (SOPs) that the team members had read. And they had signed and dated to confirm they had read and understood the processes. There was a separate SOP for the delivery of medicines to people's homes. The drivers had been read and signed this. The SOPs included processes for the Responsible Pharmacist (RP) regulations, dispensing, owings and services such as medicines use reviews (MURs) and the new medicines service (NMS). The SOPs indicated which processes needed the RP to be present and signed in for. The SOPS detailed when it was necessary for a pharmacist to complete a task. Instead of specifying the different roles that could complete different tasks.

The pharmacy had completed a risk review, dated December 2018. But this was still current with review dates in 2020. This identified different risks and rated them including risks with staff absence. And risks of dispensing errors including look alike and sound alike medicines (LASAs) and delivery errors. It identified and rated the risks of a mix up when bagging people's medicines. The pharmacy team had documented actions to help manage these risks.

The pharmacy recorded near-miss errors on a paper near miss record form. The team consistently recorded their errors each month. And records were checked back to February 2019. The team members had completed all sections with details of the medicine that had been prescribed and dispensed. And the reason for the error. The documented cause was similar on many entries. They often described the cause as 'not checking properly' rather than investigating contributing factors and causes. The team members openly discussed errors that had happened. And they were enthusiastic to describe the changes they had made to prevent similar errors in the future. It was clear that although it wasn't documented, the team discussed errors thoroughly. This was to identify the root causes of what had happened. The team members discussed an error involving the incorrect selection of gabapentin

and pregabalin. They thought a contributory factor to the incorrect selection was the positioning on the shelves. This was because they stored pregabalin under 'L' for Lyrica. By storing under 'P' for pregabalin this separated the two medicines. Also, the team had recognised both medicines contained the letters 'gaba.' And thought this may contribute to incorrect selection. They shared this to raise awareness of the risks. The team had then reviewed how they could proactively reduce similar errors with other medicines. They discussed LASA medicines and more specifically tall man lettering. They described how they were looking at four medicines. And then they would review other near miss errors to see which others to focus on. So, the first ones were amLODidipine, amiTRIPtyline, ATENolol, allopPURinol. The pharmacy had a poster to help the team introduce this. The pharmacy and its associated pharmacies shared their near miss error reviews, so the teams could learn from each other's mistakes.

The pharmacy had a separate form to record and report dispensing incidents that had reached the patient. There were a couple of examples from 2018, these included the gabapentin and pregabalin error. The pharmacy anonymously reported dispensing incidents to the National Reporting and Learning System (NRLS). The causes of these errors had been fully investigated. And the team discussed the errors together. Another example of an action the team had taken following an error was for all the team to learn about the availability of preservative free eye drops, as this had contributed to the picking error at the time.

The team members were clear about their roles and responsibilities for the tasks that needed completing in the pharmacy. During a discussion regarding the RP regulations, the team members were not completely sure what tasks could and couldn't be completed when a pharmacist wasn't signed in as the RP. As a team the regulations were understood, but as individuals they were not sure. The team would benefit from some additional training. The pharmacist displayed his RP notice for people to see. The team members were seen working within their own competence and expertise. They referred people to the pharmacist for advice appropriately. The pharmacist examined someone's feet on request and gave appropriate advice and the options available to the person. He explained how long it could take to get better. The pharmacist displayed the correct RP notice, to ensure people knew his details and responsibilities.

The pharmacy displayed a notice indicating to people how they could feed back and raise concerns. A team member described how she would try to resolve a complaint with the person. And how she would escalate the matter if needed. She described how people had complained about the availability of medicines. And the team displayed a poster to try and help people understand the shortages. The pharmacy also engaged people in feedback using an annual 'Community Pharmacy Patient Questionnaire'. But the pharmacy didn't display details of any actions taken from reviewing the results of the questionnaire.

The pharmacy had professional indemnity insurance. The details of which were discussed with the pharmacist. For the sample of entries checked, the pharmacy kept complete records in the CD register. Headers on each page were completed and entries were in chronological order. The pharmacy team members checked the balance in the register against the physical stock. They had completed monthly CD balance checks for last 3 months. Prior to this the checks had not been as regular for rarely used items. During the inspection, checks on the physical balance against the balance in the register was completed for fentanyl 25mcg patches and Zomorph 10mg capsules. The balances were correct. The pharmacy kept a record of destruction of patient returned CDs. This was in separate section in the CD register. All destruction entries had been signed and dated by a member of the team, as witness. The pharmacy had guidance to help the team report CD discrepancies and incidents to the Accountable Officer in Cheshire and Merseyside. The pharmacy kept the required records for private prescriptions. And it completed certificates of conformity for purchased unlicensed products. It didn't make records

on paper of emergency supplies. But there were some records on the computer linked to the patient medication records (PMR). These did not have a record of the nature of the emergency.

The pharmacy had submitted its Data and Security Protection (DSP) toolkit for the year. Team members including the drivers had read and signed a confidentiality clause. So, the pharmacy had made it clear to the team, the importance of keeping people's private information secure. But the team hadn't completed any further training since the introduction of General Data Protection Regulations in 2018. And the pharmacy didn't have a privacy notice available for people. The team members understood the importance of keeping people's information private. And a dispenser described how she sometimes had to talk quietly to people because the dispensary was so open to the retail area. The team kept confidential waste separately in a basket and shredded it at regular intervals.

The pharmacy has a safeguarding SOP that the pharmacy team had read. The pharmacist had completed level 2 safeguarding training. The driver and the pharmacist described examples of when they had recognised and supported potentially vulnerable people. The driver appropriately explained how he would recognise an issue and raise a concern. A team member described how she recognised how a regular patient was becoming confused. They discussed this with the surgery to get the person some support. This included starting to dispense their medicines into a compliance pack.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy team has the appropriate skills, knowledge and qualifications to effectively manage the workload. And to provide the pharmacy's services. The pharmacy team members complete some ongoing training to keep their skills up to date. And they feel comfortable to suggest ideas and raise professional concerns if needed. The team members don't have formal reviews of their performance. Instead they raise any training needs informally. So, the pharmacy may miss opportunities to support the team members to further develop their skills.

Inspector's evidence

On the day of the inspection the RP, who was one of the owners, was supported by three members of the pharmacy team; two part-time dispensers, one trainee part-time dispenser and two drivers. There were another two part-time dispensers employed, who were not present on the day. And another member of the team who had been absent for some time. The existing members of the team had increased their hours to ensure there was enough cover to manage the workload. The pharmacist tried to make sure there was always three members of the team working with him. This meant there would be enough staff present even if there was short-term absence. As the team all worked part time this allowed for greater flexibility to cover each other's holidays and absence.

One of the team was working through her dispensing course. And the pharmacist and other team members supported her. The pharmacist helped her select medicines from the shelves when she wasn't sure. The team members qualifications' certificates were seen. A team member described how she had regular 1-2-1 meetings with the pharmacist when she was studying for her qualification, but not really since. And the team members didn't have appraisals. The dispenser felt she could raise any training needs, ideas and issues informally. The team did discuss near miss errors and dispensing errors together.

The team members had recently watched the dementia friend's training video. They described how their learning had helped them understand and be more patient with people. The pharmacy kept a training records file for the team, this included SOP training. But most of the records of training were from 2017 and before. There were some more recent examples in 2019 for some members of the team, such as risk management training and learning about LASA medicines.

A dispenser described the pharmacist and part owner, as approachable. She felt she could also contact and discuss matters with the other owners. The team was not aware of a company whistleblowing policy. A team member described the questions she would ask if a person requested a product containing codeine. And the proactive advice she would give, such as not to take for more than three days. She described how she had referred people to the pharmacist when she recognised repeat requests and the risk of abuse. The owners didn't have any specific targets. They concentrated on offering services to benefit people, such as flu vaccinations.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean, secure and provides a suitable environment to deliver its services. It has a small consultation room which is adequate for people to have private conversations with the pharmacist.

Inspector's evidence

The pharmacy was clean, hygienic and tidy. It kept stock and consumables appropriately on shelves in the dispensary and stock room. It had enough bench space for the services provided. And it stored prescriptions awaiting checking on shelves to prevent the benches becoming cluttered. The lighting and heating in the pharmacy were suitable. The pharmacy had a staff toilet with separate handwashing facilities and hot and cold running water.

The consultation room was small, but adequate for the services provided. And the room portrayed a professional image with healthy living posters displayed on the walls. And a poster signposting a local sexual health service. The pharmacy displayed certificates confirming completion of training, for example for emergency hormonal contraception (EHC). But several of these were past their review date. It would be difficult for all people to access the room, as there was a step up. The pharmacy kept the door to the room open when not in use. There was no patient identifiable information kept on show in the room. But the pharmacist did store some consumables for the flu vaccination service in the room. Security would be better with a locked door.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides a range of services to help people meet their health needs. And these are mostly accessible to people. The pharmacy has suitable processes to manage its services safely and effectively. The pharmacy team members identify and monitor people taking high-risk medicines. And they provide good support to make sure they get their medicines when they need them with the appropriate advice. The team sources, stores and manages its medicines appropriately.

Inspector's evidence

The pharmacy advertises its opening hours in the window. There is a step up into the shop that would make it difficult for people with prams and using wheelchairs to access unaided. The team explained that regular patients knocked, and the team helped them in. The pharmacy had some leaflets close to the door to encourage people to pick them up. These included leaflets on cancer screening and for local services. The pharmacist was multi-lingual, and when initiated by the patient, he conversed in the most appropriate language. The pharmacy had an eye-catching display promoting healthy living. The current promotion was up to date and relevant for World Mental Health Day. There were leaflets and cards to pick up for people to access help, both locally and nationally. The team hadn’t spoken to many people due to the nature of the campaign. They felt it was difficult to start conversations and so important to have information to pick up.

The pharmacy delivered medicines to people’s homes. The driver obtained signatures when he could, but he did sign a proportion on behalf of people. The driver asked for signatures in a diary, so it was easy to identify the date of the delivery. But people signed for the receipt of their prescriptions all on one page. So, there was a risk people’s details could be shared. The pharmacist discussed how to rectify this. The driver made unattended deliveries of some medicines. But he always got verbal consent and agreed this with the pharmacist beforehand. The pharmacist had a clear understanding of the associated risks. And had reduced them by preventing unattended deliveries if the driver hadn’t been to the address before. Or if there was the possibility of children or animals in the house. There was no record of the verbal consent obtained. And the inspector discussed this with the pharmacist.

The pharmacy provided separate areas for labelling, dispensing and checking of prescriptions. The pharmacy team members used baskets when dispensing to hold stock, prescriptions and dispensing labels. This reduced the risk of them mixing up different people’s prescriptions. The pharmacy had dispensed by and checked by boxes on dispensing labels. These recorded who in the team had dispensed and checked the prescription. A sample looked at found that the team completed the boxes. The pharmacy used owing slips when it couldn't supply people’s medication in full. The patient received a slip indicating what was owed. And the pharmacy kept a second slip with the prescription. The team used the prescriptions when dispensing the owed medicine. This was observed during the inspection. The pharmacy team members were aware of the requirements of the valproate pregnancy prevention programme. And had attached the warning cards and stickers close to where they kept the valproate stock to highlight the requirement of the alert. The pharmacy had a clear process to obtain the latest blood test results for people taking warfarin. The pharmacy team worked closely with the surgeries, as the surgeries wouldn’t complete a prescription unless they had the details of the last blood test. Records of a person’s INR reading were seen documented on the PMR.

The pharmacy had started offering flu vaccinations for the season. The team was seen engaging in conversations and offering the service to its regular patients. And they showed an understanding of when it wasn't appropriate to have the vaccination. The pharmacist administered several vaccinations during the inspection. The team confirmed the service was popular and people had fed back how convenient it was to come to have their flu vaccination at the pharmacy. The team obtained all the information on the consent form before administration. And the pharmacist took the form into the consultation room, to use as part of the consultation. He had set the room up ready to administer vaccinations with gloves and an in-date Epipen. The pharmacist had an up-to-date patient group direction (PGD) available for the current flu vaccination season. This was valid until March 2020.

The pharmacy supplied medicines in multi-compartment compliance packs for around 60 to 80 people. One of the dispensers held the responsibility for ordering people's prescriptions. She ordered the prescriptions in advance to allow time to resolve queries and dispense the medication. The pharmacy spread the workload across four weeks. And it kept people's master record sheets in files associated with a particular week. The team members kept a record of when they last supplied the packs. This was used as an additional check of when the next packs were due. When the team members received the prescriptions they checked them against the master record sheet. And then prepared the labels. Another dispenser supported with the dispensing of the packs. The dispenser wrote the descriptions of what the medicines looked like, directly on to the pack. This helped the patient, carers and healthcare professionals identify the different medicines in case of a query. The pharmacy supplied patient information leaflets (PILs) with the packs. The pharmacist anotated changes to people's medication on the record sheets. Some people came to collect their packs from the pharmacy. And the team members asked for a signature to confirm collection. They had introduced this following several queries.

The pharmacy stored the medical waste bins in a separate room from the dispensary. It ordered denaturing kits in to dispose of CDs appropriately. And it stored CDs requiring safe custody in a secure CD cabinet. It stored cold chain medicines in a suitably sized fridge. The pharmacy team monitored the temperature daily and recorded it. Of the sample checked the temperature were within the required range. The fridge temperature was within range during the inspection.

The pharmacy had a SOP for date checking, and the team had read it. The team described how they completed regular date checking. And how team members were allocated different sections in the shop and the dispensary. A historical date checking schedule was available to view from early 2019, but no checks had been documented recently. So, it would be difficult to evidence these checks had been completed. The team used stickers on the manufacturer's packs to indicate when the product was short dated. Several were seen on products on the shelves. Of a sample of medicines checked, no out-of-date medicines were found on the shelves or in the CD cabinet. The pharmacy team annotated opening dates on liquid medicines.

The pharmacy used licenced wholesalers, such as AAH and Alliance. The pharmacy planned to comply with the falsified medicines directive (FMD) and had looked at options for systems and scanners. One of the other pharmacies was trialling a system. Learning would be taken before it was rolled out into this pharmacy. Pharmacy (P) medicines were stored on shelves in the dispensary, next to the dispensary stock. It was clear from the pricing and lay out which products the team members could sell. People couldn't self-select these products. The pharmacist had the opportunity to intervene in sales, if required. The pharmacy received details of drug recalls and safety alerts. And the pharmacist or a team member printed out the alert. They signed and dated the printed alert to confirm they had actioned it.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs for the services it provides. And it uses the equipment and facilities in a way that protects people's private information.

Inspector's evidence

The pharmacy had relevant resources available, including the BNF and Children's BNF. The team had access to the internet to resolve queries and to obtain up-to-date clinical information. The pharmacy had a working Omron blood pressure monitor, provided by the commissioners. The pharmacist hadn't documented when he had received it. But he thought it had been within the last twelve to eighteen months. He realised the benefit of recording when it had been received. The pharmacy team used a range of clean, glass crown-stamped measures for liquids. The pharmacy didn't have a record of electrical safety testing. But all the wires were stored tidily, and the electrical equipment was in working order.

The pharmacy kept the prescriptions awaiting collection in the dispensary so people's details on the name and address labels couldn't be seen from the pharmacy counter. The positioning of the computer monitor screens meant people in the retail area couldn't view any private information. And the computers were password protected. The pharmacy had cordless handsets, so the team could move to a private area to have confidential conversations.

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.