General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Rydale Chemists Ltd, 16 Chapel Lane, Burtonwood, WARRINGTON, Cheshire, WA5 4HF

Pharmacy reference: 1029815

Type of pharmacy: Community

Date of inspection: 26/07/2019

Pharmacy context

This is a community pharmacy in the village of Burtonwood, Warrington. The pharmacy sells over-the-counter medicines and dispenses NHS prescriptions. It also dispenses private prescriptions. The pharmacy team offers advice to people about minor illnesses and long-term conditions. And it offers services including medicines use reviews (MURs), flu vaccinations and the NHS New Medicines Service (NMS). It also supplies medicines in multi-compartmental compliance packs to people living in their own homes.

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	N/A	N/A	N/A
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 has adequate processes and written procedures to help protect the safety and wellbeing of people who access its services. It advertises how people can provide feedback. And it uses this feedback to improve its services. It generally keeps the records it must have by law but there are some gaps in records, which result in incomplete audit trails. The pharmacy keeps people's private information safe. The pharmacy team members are suitably equipped to protect the welfare of vulnerable adults and children. And they record and discuss errors they identify during dispensing to help them learn and prevent similar errors in the future.

Inspector's evidence

The pharmacy had a small, open plan retail area which led directly into the main part of the dispensary. It had a private consultation room to the side of the retail counter. The pharmacist used a rear bench to do final checks on prescriptions. A middle island was used to organise stock that that had been delivered. The dispensers used a separate bench to label and dispense prescriptions.

The pharmacy had a set of standard operating procedures (SOPs) in place. These provided the team with information on how to perform tasks supporting the delivery of services. The SOPs covered procedures such as taking in prescriptions and dispensing. The SOPs were kept in a ring binder. But there was no index available. And so, it was difficult to find a specific SOP. Many SOPs had been reviewed within the last two years. But several had not. And so, these SOPs may not have been up to date or accurately reflected the pharmacy's ways of working. A team member who had started work under a year ago had read and signed the SOPs. But another, more experienced team member had read the SOPs, but not signed them. The team member said that she had not read the SOPs for a few years. The team members were seen working in accordance with the SOPs. The pharmacy defined the roles of the team members in the SOPs. The team members said they would ask the pharmacist if there was a task they were unsure about. Or felt unable to deal with.

The pharmacy had a process to report and record near miss errors that were spotted during dispensing. The pharmacist typically spotted the error and then informed the team member that they had made an error. The team members then discussed why the error had happened. The error was rectified by the team member and then passed to the pharmacist for another check. The team member then made a record of the error into a near miss log. The records contained details such as the time and date of the errors. But the team members did not record the reason why the error may have had happened. And so, they may have missed out on some learning opportunities to improve their services. Every month, the pharmacist analysed the near miss log to check for any patterns or common trends. The findings were documented and filed. And so, the team members could read the reports whenever they wished to do so. The team members explained that they had attached alert stickers to the shelf where gliclazide was stored. This was to remind them to take more care when selecting gliclazide, as on a few occasions, they had mixed up the 40mg and 80 mg strengths. The pharmacy used a similar process to record and report and dispensing incidents. The reports were documented and filed for future reference. The team described a recent incident where a person was supplied with the lower strength of an inhaler in error. The team discussed the error to raise awareness of the importance of picking stock carefully, particularly if there were different strengths of the same medicine.

The pharmacy had a poster in the retail area which advertised how people could make comments, suggestions and complaints. The pharmacy completed a feedback survey each year. It asked people who visited the pharmacy to complete a questionnaire. The team members said that several participants of the survey had commented that they wanted a private area where they could speak to the team without being overheard by other people. The pharmacy had a consultation room which people could use. The team signposted the room and ensured that people were offered the use of the room if they asked for healthcare advice from a team member.

The pharmacy had up-to-date professional indemnity insurance. The responsible pharmacist notice did not display the correct details of the responsible pharmacist on duty. But this was corrected during the inspection. Entries in the responsible pharmacist record were not always completed each day. This is not in line with requirements. It kept complete records of supplies from private prescriptions and emergency supplies.

The team held records containing personal identifiable information in areas of the pharmacy that only team members could access. Confidential waste was placed into a separate container to avoid a mix up with general waste. The confidential waste was destroyed periodically. A privacy notice was on display in the retail area. The team members understood the importance of keeping people's information secure. The pharmacy had completed its NHS information governance toolkit.

The regular pharmacist and all the regular locum pharmacists had completed training via the Centre for Pharmacy Postgraduate Education on safeguarding the welfare of vulnerable people. The pharmacy did not have a policy on managing a safeguarding concern. And so, the team may not know how to effectively raise and manage a potential concern. The pharmacy kept the contact details of the local safeguarding teams. And so, the team members could contact the teams for advice. A team member said she had completed some training in her previous employment. But there was no evidence to confirm this. The team member gave several examples of symptoms that would raise her concerns. And said she would discuss any concerns with the pharmacist on duty, at the earliest opportunity.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has a small team with enough team members to manage the services it provides. The team members complete training when they can, to ensure their knowledge and skills are up to date. They tailor their training to help them achieve their personal goals. And they feel comfortable to suggest ways to help improve the safety of the pharmacy's services. They can raise professional concerns when necessary.

Inspector's evidence

The pharmacy employed a small team. The regular pharmacist was on duty at the time of the inspection. And he was supported by two team members. The pharmacist knew many of the people who used the pharmacy and many people were seen addressing him by his first name. And, asking him for advice of various healthcare related topics. One of the team members was a qualified pharmacy assistant and worked full-time. The other team member was a qualified counter assistant and worked part-time. The counter assistant had recently qualified and had started doing some dispensing tasks such as picking stock from shelves and inputting people data on the computer systems. But the counter assistant was not enrolled on a dispensing training course. This was discussed with the pharmacist. And the counter assistant was enrolled on a suitable course shortly after the inspection. The pharmacy also employed a part-time pharmacy assistant who was not present during the inspection. The pharmacy had employed a pre-registration trainee pharmacist, but their employment had recently ended. The pharmacist said he would be recruiting a pharmacy assistant in the next few months.

The pharmacist on duty supervised the team members. And they involved the pharmacist in offering advice to people who were purchasing over-the-counter products for various minor ailments. The team members were seen carrying out tasks and managing their workload in a competent manner. And they were asking appropriate questions when selling medicines that could only be sold under the supervision of a pharmacist. The team members accurately described the tasks they could and could not perform in the pharmacist’s absence.

The pharmacy did not provide its team members with a structured process for them to keep their knowledge and skills up to date. But it encouraged them to read literature about pharmacy services and products that the pharmacy received in the post. This helped them ensure they provided correct and relevant advice to people. The pharmacist said he had recently signed the pharmacy up to the Numark online learning system. The system contained a library of healthcare related modules which a team member could voluntarily choose to work through. The team members were not currently receiving time during the working day to train due to time constraints. The pharmacy supported its team members with an informal performance appraisal every year. The appraisals were an opportunity for the team members to discuss what parts of their roles they felt they enjoyed and which parts they felt they wanted to improve. They were also able to give feedback on how to improve the pharmacy’s services. And discuss their personal development. The counter assistant said she had recently asked for additional help when selling over-the-counter medicines. She said she was well supported by her colleagues and was able to ask questions whenever she wished to do so.

The team did not have regular, formal meetings. But as it was a small team, the team members discussed topics such as company news, targets and patient safety, when the pharmacy was quiet. If a

team member was not present during the discussions, they were updated the next time they attended for work. The team members openly and honestly discussed any mistakes they had made while dispensing and discussed how they could prevent the mistakes from happening again. The team members had recently discussed raising awareness of medicines that sounded alike or looked alike (SALADs) e.g. carbamazepine and carbimazole and how they could prevent them being mixed up in error.

The team members felt comfortable to discuss any professional concerns with the pharmacist or with the company head office personnel. They were not aware of a company whistleblowing policy. And so, the team may find it difficult to raise a concern anonymously. The pharmacy did not set the team members any targets to achieve.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is secure and suitably maintained. It has a sound-proofed room where people can have private conversations with the pharmacy's team members.

Inspector's evidence

The pharmacy was clean and portrayed a professional image. The benches in the dispensary were slightly cluttered with baskets containing prescriptions and medicines that were waiting to be put away onto the dispensary shelves. But this improved as the inspection progressed. Floor spaces were clear with no trip hazards evident. There was a clean, and adequately maintained sink in the dispensary for medicines preparation and staff use. There was a WC which had a sink with hot and cold running water and other facilities for hand washing.

The pharmacy had a sound-proofed consultation room which contained two seats. The room was smart and professional in appearance. The temperature was comfortable throughout the inspection. Lighting was bright throughout the premises.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides an appropriate range of services to help people meet their health needs. It generally stores and manages its medicines safely. And it identifies and manages the risks with delivering its services. The team members help people to safely take their high-risk medicines by giving them additional advice. And they are good at managing the risks associated with dispensing medicines in multi-compartmental compliance packs.

Inspector's evidence

The pharmacy had a push/pull door which was accessed via a step from the street. A ramp was not available. And so, some people such as wheelchair users may find it difficult to access the premises. A bell was affixed next to the entrance door. And people could use it to attract the attention of the team. The pharmacy advertised its services and opening hours in the main window. Seating was provided for people waiting for prescriptions. People could request large print dispensing labels. The team members had access to the internet. Which they used to signpost people requiring a service that the team did not offer.

The team members regularly used various stickers during dispensing and they then used these as an alert before they handed out medicines to people. For example, to highlight interactions between medicines or the presence of a fridge line or a controlled drug that needed handing out at the same time. The team members signed the dispensing labels to indicate who had dispensed and checked the medication. And so, a robust audit trail was in place. The dispensary had a manageable workflow with separate areas for the team members to undertake the dispensing and checking parts of the dispensing process. They used baskets to hold prescriptions and medicines. This helped the team members stop people's prescriptions from getting mixed up. The team used stickers to document the last day of handout of CDs that did not require safe custody. This system prevented the team members from handing out any CDs to people after their prescription had expired. Owing slips were given to people on occasions when the pharmacy could not supply the full quantity prescribed. One slip was given to the person. And one kept with the original prescription for reference when dispensing and checking the remaining quantity. The team attempted to complete the owing the next day. The pharmacy did not officially offer a service to deliver medicine to people's homes. But the pharmacist would occasionally deliver medicines to people's homes after the pharmacy had closed, if they were housebound. The pharmacy did not keep a record of these deliveries. And so, the team may find it difficult to resolve a potential query.

The team members were aware of the risks associated with the supply of high-risk medicines such as warfarin, lithium and methotrexate. They were able to demonstrate how prescriptions for these medicines would be brought to the attention of the pharmacist, particularly if the medicine was new to a person. The pharmacist often gave the person additional advice if there was a need to do so. But details of these conversations were not recorded on people's medication records. So, the pharmacy could not demonstrate how often these checks took place. INR levels were not always assessed in the pharmacy. The team members were clear about the requirements of the valproate pregnancy prevention programme. And they were aware of the risks. And they demonstrated the advice they would give people in a hypothetical situation. A poster which gave details of the programme was displayed on a wall in the retail area. The team members had access to literature about the programme

that they could provide to people to help them take their medicines safely. The team had not completed a check to see if any of its regular patients were prescribed valproate and met the requirements of the programme.

The pharmacy supplied medicines in multi-compartmental compliance packs for people living in their own homes. The team members completed the dispensing for these packs on a rear bench away from the retail counter. This was done to prevent any distractions, such as people waiting to be served. The team members were responsible for ordering the person's prescription. And they did this around a week in advance, so they had ample time to manage any queries. And then the prescription was cross-referenced with the person's medication record to ensure it was accurate. The system worked on a four-week cycle. And each person who received a pack was assigned a start week e.g. week 2. The pharmacy tried to keep a similar number of people within each week to ensure that the workload remained similar across each week. The prescriptions and other documents for each person were kept in colour-coded wallets which related to each week. The team members supplied the packs with dispensing labels attached. And with information to help people visually identify the medicines. The team members supplied patient information leaflets with the packs each month.

Pharmacy only medicines were stored behind the pharmacy counter. The storage arrangement prevented people from self-selecting these medicines. The pharmacy had a date checking schedule to be completed every three months and it used stickers to highlight short-dated stock. It kept a record of the process. Some short-dated stickers were seen on the dispensary shelves. The team members recorded the date liquid medicines were opened on the pack. So, they could check they were in date and safe to supply. The pharmacy stored some loose tablets and capsules in bottles that did not have any information of their expiry dates. And so, the pharmacy could not be sure that they were fit for purpose. This was discussed with the team and the bottles were removed to be destroyed.

The team members were not currently scanning products or undertaking manual checks of tamper evident seals on packs, as required under the Falsified Medicines Directive (FMD). No software or scanners were available to assist the team to comply with the directive. The team members had not received any training on how to follow the directive. The pharmacist said that he expected the pharmacy to be fully compliant with the directive at the end of 2019.

Fridge temperatures were recorded daily using digital thermometers. A sample of the records were looked at. And the temperatures were found to be within the correct range. The pharmacy obtained medicines from several reputable sources. Drug alerts were received via email to the pharmacy and actioned. But the pharmacy did not keep a record of the action taken. And so, there was no audit trail in place which could be used to resolve a query.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy's equipment is clean and safe to use. And the pharmacy suitably protects people's confidentiality.

Inspector's evidence

References sources were in place. And the team had access to the internet as an additional resource. The resources included hard copies of the current issues of the British National Formulary (BNF) and the BNF for Children. The pharmacy used a range of CE quality marked measuring cylinders. And it had tweezers and rollers available to assist in the dispensing of multi-compartmental compliance packs. The fridge used to store medicines was at capacity. And the medicines inside were organised in an orderly manner. Prescription medication waiting to be collected was stored in a way that prevented people's confidential information being seen by members of the public. And computer screens were positioned to ensure confidential information wasn't on view to the public. The computers were password protected. Cordless phones assisted in undertaking 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.