General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Aston Pharmacy, 2 Station Road, Great Sankey, WARRINGTON, Cheshire, WA5 1RQ

Pharmacy reference: 1029851

Type of pharmacy: Community

Date of inspection: 11/03/2020

Pharmacy context

The pharmacy is on a parade of shops in a residential area. It mainly dispenses NHS prescriptions and sells over-the-counter medicines. It supplies some people's medicines in multi-compartment compliance packs to help them take their medicines. And it delivers medicines to people's homes. The pharmacy provides a range of services including seasonal flu vaccinations and the Community Pharmacist Consultation Service (CPCS).

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 appropriately identifies and manages the risks to its services. It has up-to-date procedures to help the team members work safely and effectively. And it asks people for their feedback about the pharmacy's services. The team members keep people's private information secure. And they know their role in helping protect the wellbeing of vulnerable people. The team members respond well when they make mistakes whilst dispensing. They record their mistakes so they can make suitable changes to reduce the risk of the same mistake happening again. They mostly make the records they must by law.

Inspector's evidence

The pharmacy had a set of standard operating procedures (SOPs) for the range of services provided. This included SOPs for dispensing, Responsible Pharmacist (RP) regulations and controlled drug (CD) management. The SOPs had recently been updated. And for the SOPs checked, the issue dates were September and October 2019. The team members were in the process of reading these updated SOPs. This had been delayed due to reduced staffing levels. The SOPs were not in a file but separated into sections to direct which team members needed to read which SOPs. They didn't yet have a completed training record for these SOPs. The new member of the team, who had only started that week had not read any SOPs, but she was working under close supervision of the pharmacist. Roles and responsibilities were detailed in the SOPs. On one occasion a team member was observed repeating the person's name and address back to them rather than asking for their details. This was not as detailed in the SOP. The driver couldn't remember reading the delivery SOP. And he wasn't following all the steps documented in the SOP. This included getting signatures from people on delivery.

The pharmacy team members had identified some of the risks associated with the ongoing Covid 19 pandemic. They had sought to inform people of the ongoing requirements by creating a display of information in the healthy living area of the pharmacy. They had displayed several posters around the pharmacy of the symptoms. They had thought to reduce unnecessary footfall into the pharmacy by displaying a notice on the window to inform people they didn't have any hand sanitiser in stock. But they had not thought about informing people who had symptoms of Covid 19 not to enter the premises to help protect other people and the pharmacy team. They were not displaying the up-to-date posters on the door to the pharmacy asking people with symptoms not to enter. The pharmacist was aware of the NHS SOP and had briefly read it with regards to isolating people in the consultation room if necessary.

The pharmacy team members were aware of the increased risks of incorrectly selecting look-alike and sound-alike (LASA) medicines. They had attached alert stickers in front of medicines and had moved some of these medicines to different shelves to separate them. This included atenolol and amitriptyline. There was a sticker in front of azathioprine and azithromycin. But a box of azathioprine had been incorrectly put away and it was being stored with the azithromycin on the dispensary shelves. This was rectified. The pharmacist shared this finding with the rest of the team and highlighted that the alert sticker could have potentially confused the person putting stock away. She described how she would further discuss this with the team to assess the risk. The pharmacy used a near miss error log. And the team completed some entries each month. The pharmacist had recently changed the process in the last few months to recording near miss errors on one log rather than people's individual logs. So, it was

easier to spot patterns and trends. The pharmacy team was aware of the importance of recording and learning from near miss errors. The pharmacy reported dispensing incidents and the team evidenced some previous reports. These documented the learnings and actions taken to reduce the risk of a similar error. But a recent error had not been reported, as it had been identified as a patient preference and not an error. The pharmacist reflected on the information and agreed that the incident was to be reported.

The team members had a clear understanding of their roles and responsibilities. The newest member of the team was observed asking other team members and the pharmacist to help resolve people's queries. The RP notice was incorrect, but this was changed during the inspection. The pharmacy had a notice displayed indicating to people how they could provide feedback and raise concerns. The team had questionnaires on the counter initiated from the local patient participation group at the local health centre. There was a question regarding minor ailment advice at the pharmacy. So, the pharmacy would get feedback on this aspect of their service. The pharmacy team explained how any concerns escalated to the head office were taken seriously. And a staff member from head office would visit the pharmacy to discuss the complaint with the team.

The pharmacy had up-to-date professional indemnity insurance. It kept RP records electronically. Several entries in the last month were incomplete as there was no time entered when the RP had signed out. The pharmacy had a large bound private prescription book. It had entries that started in 1955 written in fountain pen ink. The recent entries were clear, legible and complete. No emergency supply records were seen entered recently. The pharmacist described how the pharmacy didn't make many emergency supplies as it provided the community pharmacist consultation service (CPCS) service. Entries of these emergency supplies had not made in the private prescription book as the pharmacist had been unaware of the requirement. A sample of records for unlicensed products looked at mostly met the requirements of the Medicines and Healthcare products Regulatory Agency (MHRA). A few records checked didn't have the prescriber's details completed on the certificates of conformity. A sample of the controlled drugs (CD) register looked at mostly met legal requirements. The team had not completed all the headers, or the address of the wholesalers the pharmacy used. And there was an occasional crossing out in the CD register. The pharmacy regularly completed balance checks when a CD was dispensed. It didn't complete regular checks for rarely used items. When checked the quantity of MST 10mg tablets and MST 15mg tablets, these matched the quantity recorded in the register. But the expiry date and batch number on the packaging of MST did not match the expiry date and batch number on the blisters on the inside of the packaging. The pharmacist recognised the issues and risks with this. The pharmacy had a CD destruction register for CDs that people returned to the pharmacy.

The pharmacy displayed a privacy notice and had a SOP relating to the general data protection regulation (GDPR). The team members could not describe any formal training they had completed with regards to GDPR or information governance (IG). But the team members understood their roles in protecting people's private information. The pharmacy separated confidential waste into a clearly labelled basket. The team shredded the confidential waste. The team members described ways they protected people's private information when discussing personal matters on the telephone.

The pharmacist and pharmacy technician completed level two safeguarding training every two years and had recently completed the CPPE training. The pharmacy team, including the driver had received training relating to their role in safeguarding vulnerable people. And they had completed dementia friends training. They understood their role in helping protect the wellbeing of vulnerable people.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has a team with the required skills and knowledge for the services it provides. Its team members complete some ongoing learning to keep these skills and knowledge up to date. They work well together to manage the workload. And the experienced team members support the member in training to help them resolve queries. Team members can use their professional judgment to make decisions. And they feel comfortable in raising any professional concerns if necessary.

Inspector's evidence

The RP was the pharmacist manager. She was supported on the day by two part-time dispensers, a delivery driver and a part-time trainee medicines counter assistant (MCA) in her first week of work. The MCA was yet to be enrolled on an accredited course and yet to read the SOPs. The pharmacy also employed a part-time pharmacy technician who was not working on the day of the inspection. The pharmacy team members displayed their qualification certificates in the consultation room, including NVQ 3 and healthy living level two certificates. The team members were seen managing the workload together. They discussed tasks and queries to help ensure they worked effectively. And supported the new MCA to resolve queries. The pharmacy used holiday forms to plan cover to make sure there was enough people working to deliver the pharmacy's services.

The team members listened to people's requests and queries. They were seen responding to queries and contacting the surgeries to resolve issues within their competence. They referred queries to the pharmacist appropriately. The team member who had started that week was seen relaying information to the pharmacist and other team members regarding requests from people waiting in the pharmacy. The pharmacist was seen closely supervising these discussions. A team member appropriately described what questions she would ask if a person requested to buy co-codamol. And how she would escalate any concerns and repeat requests to the pharmacist so they could use their professional judgement about the supply.

The team members worked together well sharing the workload and communicating well. They used a white board to communicate messages and to document tasks such as the fridge temperature checks. They spoke freely during the inspection. Team members felt comfortable to raise concerns with their colleagues, the pharmacist manager and with people working in head office. The team members knew of the company's whistleblowing policy. And were confident they would be able to find the details if they needed.

The pharmacist and technician completed training relevant to their roles. This included recent training relating to sepsis, risk management and LASA medicines. Not all team members were clear about the ongoing training they completed. But they could remember their learnings from briefings about changes to recent CD legislation changes and their role in the Covid 19 pandemic. This information was cascaded from head office. The pharmacy had made some Numark training and information packs available to the team. Some team members had completed healthy living pharmacy training last year. And some had attended a meeting regarding the emergency hormonal contraceptive (EHC) service. And were able to use their professional judgment to make decisions relating to services and meeting targets.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is relatively clean, hygienic and it is secure. It provides an adequate space for the services provided. There is limited storage space, so some areas of the pharmacy appear cluttered. It has an adequate consultation room so people can talk to team members in private.

Inspector's evidence

The pharmacy was suitably clean and hygienic. It was secure. The toilet facilities were clean with hot and cold running water. And a sign “how to wash your hands.” The team stored some compliance pack consumables in the toilet area and in the consultation room. This was due to the restricted storage space in the pharmacy. Although not ideal these were stored neatly on high level shelves. The storage space in the dispensary was adequate, but the space was tight. The benches appeared cluttered with a number of baskets stored there. The team had stored some multi-compartment compliance packs in baskets, on the floor awaiting checking. These were stored neatly away from the walk way, so they didn’t present a trip hazard. But the storage of these packs in these areas was not ideal. There was a staff area for making drinks with a sink. The pharmacy had air-conditioning and heating to keep the temperature comfortable. The lighting was sufficient. The pharmacy had a separate sink in the dispensary with hot and cold running water and handwash.

There was access to the consultation room from the dispensary and retail area. The pharmacy had constructed a physical barrier, close to the consultation room to prevent people from approaching too close to the dispensing area. The consultation room was relatively small, but suitable for the pharmacy’s services. It did appear somewhat cluttered with boxes and other items stored in there. It had a sign, printed in the pharmacy indicating it was a consultation room.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides services that support people's health needs. And it generally manages its services appropriately. The team members recognise the importance of supporting people taking higher risk medicines. And they provide these people with relevant advice and written information to help them take their medicines safely. The pharmacy obtains its medicines from reputable sources. And it mostly stores and manages its medicines appropriately. But the team members don't always prioritise checking the expiry dates of medicines. So, there is a risk some medicines are not fit for purpose.

Inspector's evidence

The pharmacy had a small step up into the shop. It didn't have any handles or other ways to assist people in stepping up to enter the pharmacy. It would be difficult for people using wheelchairs to enter the pharmacy in this way. The pharmacy provided a home delivery service to help make services accessible. A team member described how the pharmacy had an arrangement with one of the regular customers, whereby they came to the side staff only entrance and knocked on the door. The pharmacy advertised its opening hours and services. It displayed health promotion posters and leaflets in the pharmacy. The pharmacy provided the community pharmacist consultation service (CPCS). The pharmacist described how she provided the service and the checks she made. On occasions the referrals were not appropriate. An example included when she had referred a person back after checking the person's summary care records (SCR) and made the professional decision that it was inappropriate to supply an inhaler.

The pharmacy team members used baskets throughout the dispensing process, to help reduce the risk of error. They kept a dispensing audit trail by signing the dispensed by and checked by boxes on the dispensing labels. The pharmacy had an organised workflow, with separate areas for labelling, dispensing and checking prescriptions. Although some areas were cluttered, the team kept a clear area for dispensing on the middle dispensing bench. The pharmacist kept their checking area free from clutter. The team stored the baskets awaiting checking on a different bench. The team used stickers to highlight certain medicines, this included CDs and fridge lines. The pharmacist was aware of the safety alert regarding valproate and the risks in pregnancy. The pharmacy had some valproate stock in the old packaging without the required warnings on the pack. This stock was found to be out-of-date and so removed. The pharmacy had completed audits relating to high-risk medicines. This included for lithium and valproate. Of the people the pharmacy supplied valproate to none had been identified as requiring a pregnancy prevention programme. The pharmacy had warning cards available for the team to supply with valproate. And it had books to supply to people taking methotrexate if required. The pharmacy made deliveries to people's homes. The team members printed an additional name and address bag label to stick on the delivery sheets. These documented which deliveries were to be made on that day. This created a record in case of queries. And allowed the delivery driver to plan his route. As the delivery driver made his deliveries, he annotated the order in which he made them in case there was a query or a mistake. He didn't get signatures from people, which wasn't in line with the SOP.

The pharmacy provided some people with their medicines in multi-compartment compliance packs, to help people take their medicines as prescribed. The pharmacy had a SOP detailing the process. The service was organised by the pharmacy technician, with other team members helping to assemble the packs. The work was spread over four weeks to make the workload more manageable. The technician

checked the prescriptions they received back from the surgery. And contacted the surgery with any queries and missing prescriptions. From a sample of packs checked the backing sheets detailed the medicine in the pack and when to take it. But they didn't detail the required warning instructions, for example 'may cause drowsiness' and 'swallow whole.' Some backing sheets detailed descriptions of what the medicines looked like. But these were not present on all and when present the descriptions were basic, for example, white tablets. This would make it difficult to identify a tablet in the pack in case of a query or change in medication. The pharmacy sent patient information leaflets (PILs) with the packs every four weeks.

The pharmacy used several licenced wholesalers to obtain its medicines. It stored its medicines appropriately on shelving in the dispensing areas. It kept Pharmacy (P) medicines on shelves behind the counter. This allowed the pharmacist to supervise sales as required. The pharmacy stored fridge lines neatly in the fridge, that was of a suitable size. The team recorded fridge temperatures, these were seen to be within the required range of two to eight degrees Celsius. The pharmacy had suitable medicinal waste bins for disposal of medicines. But paper waste was identified in the medicinal waste bin in the dispensary. The CD cabinet was full of stock and didn't allow for full separation of the stock. The team stored out-of-date CD stock and patient returned CD stock separately. It stored the patient returned CD destruction register in the CD cabinet, which took up valuable space.

The pharmacy used a date checking schedule. The team members signed and dated the schedule when they had completed the checks. The last recorded date was September 2019. The pharmacist indicated that there was another task schedule and on this record the date checking had been completed last on 19 November 2019. These two records were confusing and there wasn't a clear audit trail of checks. The team members described the process of how they planned the checking of expiry dates every three months and how they used stickers to indicate short-dated stock. They knew they hadn't completed the checks recently. They explained this was because they had been working with reduced staffing levels. A new member of staff had started that week, so they had plans to get back up to date. They had discussed the increased risk of out-of-date medicines being stored on the shelves, so they were vigilant to check expiry dates during the dispensing and accuracy checking processes. Several out-of-date medicines were removed from the shelves. These mainly expired in February 2020. Not all of these were highlighted with short-dated stickers as was the pharmacy's process. The team annotated the opening date on some liquids.

The pharmacy kept printed records of medicine recalls and safety alerts. The team members signed and dated the alert once the required actions had been completed. They had actioned recent recalls. The pharmacy had the equipment and software to be compliant with the falsified medicines directive (FMD). And the team described how they had previously completed the decommissioning process. But at the time many of the barcodes had not scanned and so they had stopped.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs to provide its services appropriately. And the team mostly uses these in ways to maintain people's privacy.

Inspector's evidence

The pharmacy had reference resources such as the British National Formulary (BNF) and access to the internet to obtain up-to-date clinical information. The pharmacy team used a range of glass, crown stamped measures for measuring liquids. The pharmacy had cordless telephone handsets. These allowed the team members to have telephone conversations towards the back of the dispensing area to maintain people's privacy. The pharmacy team members used their individual NHS smartcards to access people's medication records. This helped to keep people's confidential medical information secure. The pharmacy's computer screens were positioned so unauthorised people couldn't see confidential information. The team stored prescriptions awaiting collection in the dispensary, so not private details could be seen from the retail area. The pharmacy had put up a tensor barrier to restrict people access to one part of the dispensing area near the consultation room. But on occasions team members discussed people's prescriptions from the dispensing area. These conversations could potentially be heard by other people in the 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.