General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: David Jarvis Ltd, 43 Eastbourne Road, MIDDLESBROUGH, Cleveland, TS5 6QN

Pharmacy reference: 1029938

Type of pharmacy: Community

Date of inspection: 06/02/2020

Pharmacy context

This is a community pharmacy in Middlesbrough, Cleveland. It dispenses both NHS and private prescriptions and sells a range of over-the-counter medicines. The pharmacy team offers advice to people about minor illnesses and over the counter medicines. It provides NHS services; such medicines use reviews. It supplies some medicines in multi-compartment compliance packs to people living in their own homes. And it provides a home delivery service.

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 identifies and manages risks associated with the services it provides to people. And it has a set of written procedures for the team members to follow, but these are not signed or dated. So, the team may not be working consistently. It keeps the records it must have by law. And it keeps people's private information secure. It acts on the feedback it receives from people who use the pharmacy to improve services. The team members discuss and usually record mistakes they make when dispensing. But not all near misses are recorded so the team sometimes does not have all the information to identify patterns and learn from them.

Inspector's evidence

The pharmacy was long and thin and there was an adequately sized retail area and dispensary. There was an established work flow with separate areas for dispensing and checking.

The pharmacy had a set of standard operating procedures (SOPs). These were not signed or authorised for use by the current superintendent who was also the pharmacy manager. There were some team members signatures to show that they had been read in February 2017. There were no dates on the SOPs and no review date. This meant that the pharmacy team members may not be working consistently. For example, pharmacists were using two different processes to log in as responsible pharmacist. One was a paper log and the other electronic. And the SI was unsure of the contents of the responsible pharmacist SOP. The inspector discussed the necessity to have an up to date SOP for this with the SI.

The manager described the system for recording near miss errors made by the team when dispensing. He advised that he highlighted near miss errors made by the team when dispensing. There was an NPA miss log that the team could use to record the details of each near miss error. But it had not been used since December. No near misses were recorded in January or February. The manager explained that sometimes the team members were too busy to enter them up. And the ACT had left recently, and she made sure they were entered and reviewed. Near misses were previously being recorded. And the team provided examples of changes made following dispensing incidents. For example, esomeprazole capsules and tablets were being confused, so they had been moved to different shelves in the pharmacy. There had been a dispensing error when an extra tablet was put into a person's compliance pack. The manager asked staff to count the tablets needed before filling the packs.

The pharmacy had a complaints procedure in place. And details were displayed in the retail area. There had been no complaints made since the SI had been in post. The pharmacy collected feedback through an annual patient satisfaction questionnaire. And following feedback they were now offering lifestyle advice as a healthy living pharmacy.

The pharmacy had up-to-date NPA professional indemnity insurance in place valid until 31 March 2020. There was a dual system for logging in as RP. This was confusing and the SI said that he would update the SOP so that one system was used by all. The pharmacy kept complete paper records of private prescription and emergency supplies. The pharmacy kept CD registers. And they were completed correctly. The pharmacy team checked the running balances against physical stock regularly. A stamp

was used to indicate that the balance had been checked and verified. A physical balance check of a randomly selected CD matched the balance in the register. The pharmacy kept complete records of CDs returned by people to the pharmacy. The pharmacy held certificates of conformity for unlicensed medicines and they were completed in line with the requirements of the Medicines & Healthcare products Regulatory Agency (MHRA).

The team was aware of the need to keep people's personal information confidential. There was an information governance file with a training booklet. The SI said that the team had read it. But there were no team signatures to confirm this. The team held records containing personal identifiable information in areas of the pharmacy that only team members could access. Confidential waste was segregated to avoid a mix up with general waste. The confidential waste was periodically shredded off site.

When asked about safeguarding, the SI confirmed that she had completed level 2 training. There were no local contact details in the pharmacy. The SI said that he would look these up if necessary. No safeguarding concerns had been raised.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy team members have the appropriate qualifications and skills to provide the pharmacy's services safely and effectively. Staff receive training, but there are no annual appraisals so learning needs may be missed.

Inspector's evidence

At the time of the inspection the responsible pharmacist was the manager and SI. He was supported on the day by three dispensing assistants and one ACT. The ACT worked between the branches. And one trainee dispensing assistant. The pharmacy team members thought that they managed with the current level of staff. During busy times and holidays staff from other local branches helped to provide cover when necessary.

People were acknowledged as soon as they arrived at the pharmacy counter. The member of the pharmacy team on the counter was taking time to speak with them if they had any queries. The team had received healthy living pharmacy training. And training on inhaler technique. The pharmacy team members received on the spot feedback. But not regular appraisals. The pharmacy team members discussed tasks that needed to be completed. And they discussed any dispensing incidents as they occurred. No notes were taken of meetings or discussions. The pharmacy team were not aware that there was a whistle blowing policy. But said that if they had any concerns then they would speak to the SI or the area manager. There were no targets set. But the team tried their best to provide a good service to people. The manager thought the team worked well together.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is kept secure and is well maintained. The premises are suitable for the services the pharmacy provides. It has a sound-proofed room where people can have private conversations with the pharmacy’s team members.

Inspector's evidence

The retail area was clean and professional in its appearance. With a seating area for people waiting for their prescriptions. The dispensary was adequately sized. There was a clean, well-maintained sink in the dispensary for medicines preparation and staff use. There was a toilet with a sink with hot and cold running water. The pharmacy had a sound-proofed consultation room with seats where people could sit down with the team member. The room was professional in appearance and was signposted by a sign on the door. There was a chaperone policy which was displayed. There was also a computer. The room was protected from unauthorised access by a key pad entry system.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy’s services are easily accessible to people. The pharmacy manages its services appropriately and delivers them safely. It provides medicines to some people in multi-compartment packs to help them take them correctly. And it suitably manages the risks associated with this service. The pharmacy sources its medicines from licenced suppliers. The pharmacy may not always give advice to people taking high risk medication. And when they do this is not routinely recorded. So, it may not be able to refer to this information in the future if it needs to.

Inspector's evidence

There was direct access to pharmacy from the street which was on the same level. So, people with mobility issues and wheelchair users could enter the pharmacy. The pharmacy advertised its services and opening hours in the window. It stocked a range of healthcare related leaflets in the retail area, which people could select and take away with them.

The team members signed the dispensing labels when the dispensing and checking processes were complete. And so, a robust audit trail of the process was in place. They used baskets to hold prescriptions and medicines. This helped the team members stop people's prescriptions from getting mixed up. 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 pharmacy delivered medicines to people in their homes. This was a free service. The pharmacy got signatures from people who they delivered medicines to. And so, an audit trail was in place that could be used to solve any queries.

The pharmacy supplied medicines in multi-compartment compliance packs for around one hundred and fifty people living in their own homes. The team prepared these on a side bench and part of the central working bench. Two members of the pharmacy team usually prepared these. People had a MARR sheet and any changes to medication were recorded on the sheet. They were also recorded on the persons electronic record. Team members recorded details of conversations they had with people’s GPs in the communication book. They supplied the packs with information which listed the medicines in the packs and the directions. And information to help people visually identify the medicines. For example, the colour or shape of the tablet or capsule. It also provided patient information leaflets with the packs it supplies.

The pharmacy dispensed high-risk medicines for people such as warfarin. The manager said that there was no process for counselling these people. The pharmacist would usually discuss warfarin doses and INR monitoring at an MUR. The manager confirmed that any conversations were not usually recorded onto the patient record. The SI was aware of the pregnancy prevention programme (PPP) for people who were prescribed valproate, and of the risks. The SI confirmed that they had no eligible people receiving valproate. He was unable to locate the valproate information pack. But he said he would follow this up.

Pharmacy medicines (P) were stored behind the pharmacy counter to prevent people self-selecting them. The pharmacy shelves were reasonably tidy. The team members checked the expiry dates of its

medicines to make sure none had expired. They did this when they had time. And the team members used alert stickers to help identify medicines that were expiring within the next six months. They recorded the date liquid medicines were opened on some packs. Morphine liquid was found on the shelf which had been opened but was not dated. This was removed for destruction. The pharmacy had procedures in place to appropriately store and then destroy medicines that had been returned by people. And the team had access to CD destruction kits.

The team was not currently scanning products or undertaking manual checks of tamper evident seals on packs, as required under the Falsified Medicines Directive (FMD). The team had not received any training on how to follow the directive. The team members were unsure of when they were to start following the directive. Drug alerts were received electronically to the pharmacy and actioned. There was an audit trail for this. The pharmacy checked and recorded the fridge temperature ranges daily. And a sample checked were within the correct ranges. The CD cabinet was secured and of an appropriate size. The medicines inside the fridges and CD cabinets ere well organised.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy’s equipment is well maintained and appropriate for the services it provides. The pharmacy uses its equipment to protect people’s confidentiality.

Inspector's evidence

The pharmacy had copies of the BNF and the BNF for children for the team to use. And the team had access to the internet as an additional resource. The pharmacy used a range of CE quality marked measuring cylinders. The pharmacy used a hand pump to measure methadone. And this was cleaned daily. The team members used tweezers and gloves to help dispense multi-compartment compliance packs. The fridges used to store medicines was of an appropriate size. The electrical equipment looked to be in good working order. 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 seen by unauthorised people. The computers were password protected to prevent any unauthorised access. The pharmacy had cordless phones, so the team members could have conversations with people in private.

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.