General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Pharmacy Express, 113 Lanehouse Road, Thornaby, STOCKTON-ON-TEES, Cleveland, TS17 8AB

Pharmacy reference: 1029999

Type of pharmacy: Community

Date of inspection: 12/08/2019

Pharmacy context

The pharmacy is on the outskirts of the town centre. It dispenses NHS and private prescriptions and sells over-the-counter medicines. And provides advice on the management of minor illnesses and long-term conditions. The pharmacy delivers medicines to people's homes. It supplies medicines in multi-compartmental compliance packs, to help people remember to take their medicines. And it provides NHS services such as flu vaccinations, the Community Pharmacy Referral scheme (CPRS), NHS Urgent Medicines Supply Advanced Service (NUMSAS) and supervised methadone consumption.

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	2.2	Good practice	The pharmacy encourages learning, with training available, and the pharmacy team works well together in a supportive environment.
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 written procedures that the team follows. The team members have a clear understanding of their roles and tasks. And they work in a safe way to provide services to people using the pharmacy. The pharmacy provides people using the pharmacy with the opportunity to feedback on its services. The pharmacy team members look after people's private information. And they know how to protect the safety of vulnerable people. The team members responsibly discuss mistakes they make during dispensing. But the detail they record is sometimes limited. So, they may be missing out on some learning opportunities to prevent similar mistakes from occurring. The pharmacy generally keeps all the records as required, by law in compliance with standards and procedures. But some minor gaps in these records occasionally result in incomplete audit trails.

Inspector's evidence

The pharmacy had up to date standard operating procedures (SOPs) which the pharmacy team members have read. These provided the team with information to perform tasks supporting delivery of services. They covered areas such as the dispensing prescriptions, responsible pharmacist and controlled drugs (CD) management. These were last reviewed in March 2018. The SOPs had signature sheets and the team had read and signed the sections relevant to their role. The superintendent went through the SOPs with the team to ensure they understood them. The team could advise of their roles and what tasks they could do.

The pharmacy workflow provided different sections for dispensing activities with dedicated benches for assembly and checking, with a separate room for compliance pack preparation and the medicines for the home. The team utilised the limited space well. There were different workstations and the team members were allocated workstations and roles on a rotating process of three months. There was a dedicated checking island.

The pharmacy team members used baskets throughout the process to keep prescriptions and medicines together. They used different colours of baskets with red for waiting and call back, other colours for the repeats and electronic prescriptions. They marked the deliveries on the bag labels. This helped to distinguish people's prescriptions by degree of urgency and this helped plan workload. It ensured that completed items were stored appropriately with delivery sections for different days.

The pharmacy recorded near misses found and corrected during the dispensing process. The team recorded these on a specific template. The team members generally entered their own. Some of the team members completed entries with a bit more detail but generally detail was limited. Examples included wrong quantities, but the team did not usually indicate what should have been the amount and what had been supplied. Some entries indicated the wrong form of drug such as metformin with ordinary supplied instead of the modified release version. The team generally had limited detail for any actions required. The pharmacist discussed the near misses and the team and shared learning, at the time. They pharmacy had previously maintained written reviews, until May time but had had some staff changes and this had lapsed. It had been reinstated this month following a review of team roles. The team had access to some resources to assist in completion of the near miss logs. And the superintendent (SI) allocated this task to the technician going forward. They had a few shelf alerts in place to highlight to the team at the picking stage and discussed developing this more.

There was a formal complaints process in place and the team had read the SOP for the process. The team completed any complaints online and informed the SI. Most of the team knew how to enter and complete the online form to ensure the pharmacy reported it as soon as possible. There was a suggestions box on the counter for people to place any comments for feedback. The pharmacy gathered feedback through the annual patient satisfaction survey. And displayed these in the pharmacy. The results had been very positive in all areas. The pharmacy had current indemnity insurance with an expiry date of 31 August 2019. The SI was aware of its required renewal. The pharmacy displayed the correct responsible pharmacist (RP) notice. And the pharmacists completed the responsible pharmacist records generally as required. The SI realised that he had not always signed out and had reviewed his process and reminded others. The pharmacy kept the records for private prescriptions electronically with few emergency supply (ES) reasons due to people using the NHS Urgent Medicines Supply Advanced Service (NUMSAS). The pharmacy kept special records for unlicensed products with the certificates of conformity completed.

A sample of the CD registers looked at had most of the headings completed as required. On occasions one or two had been missed. The pharmacy undertook monthly running balance checks for CDs but did not keep running balances of methadone. The SI discussed this and accepted it was good practice. There were a few entries over the year that had been corrected but these had all been suitably annotated, clearly showing the nature if the error. These included several where the running balances had been incorrect for a few entries before anyone had noticed that it had been wrong. They were usually arithmetic errors. The SI advised that all the team required to check the running balance at each time of supply, so this should not occur going forward. The pharmacy recoded any late entries as such in the register. There were fewer wrong entries in the recent months. Physical stock of an item selected at random agreed with the recorded balance. The team knew to contact the accountable officer if there were any unresolved discrepancies. The pharmacy had a system that the team placed all prescriptions for CDs in a box once supplied and all entries made around 5pm each evening.

The pharmacy kept a record of CDs which people had returned for disposal on sheets of paper specifically for this purpose. They had stapled some sheets together, but some were loose, and the pages were not numbered. The pharmacy marked any items as returned CDs for destruction, using coloured labels. They generally recorded these, but the records were messy. The pharmacy had recently destroyed some (6/8/19) but had some still waiting destruction from April 2019. The pharmacy had received some patient returns this day. They had marked these as such and placed in the CD cabinet but not entered on the sheet. A few of the entries had not had a signature of the witnesses. And one or two had no signatures but it was advised they had been destroyed and people had not recorded properly.

The team had training on Information Security which included General Data Protection Regulation (GDPR) information. The pharmacy displayed information on the confidential data kept and how it complied with legislation. The IT system was password protected. The computer stored patient medication records (PMRs) electronically. And the team stored completed prescriptions safely. The pharmacy team stored confidential waste in separate containers for safe disposal. Safeguarding information including contact numbers for local safeguarding were available for the team. The pharmacists and technician had undertaken level 2 CPPE training, with some others completing level 1. The pharmacy computer had the contact details for safeguarding organisations.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has a team with the qualifications and skills to support the pharmacy's services. It encourages learning and provides training to team members tailored to the services they provide. And it offers all team members opportunities to complete more training. The pharmacy provides feedback to team members on their performance. So, they can identify opportunities to develop their career. The pharmacy team members share information and learning so, they can improve their performance and skills. They support each other in their day-to-day work. And they feel comfortable raising any concerns they have.

Inspector's evidence

There was one pharmacist, one technician, four dispensers and one medicine counter assistant (MCA) working in the pharmacy. And there was a new member of staff who had started about six weeks ago and she was waiting to start the MCA course. She was then going on to do the dispensing course. A second pharmacist was present as he often worked from an office within the building. Most days there was a second pharmacist, with one of the owners present, usually spending most of the time in the office. And they assisted in the dispensary when required. In addition, there was a pre-registration graduate who worked 40 hours a week and an accuracy checking technician (ACT) who worked 19 hours a week. There was a driver who was not present, and the MCA was undertaking the deliveries, with the second pharmacist doing one or two as required to assist. The team worked a range of hours, with four of the team working 40 hours weekly and the rest working between 16 and 30 hours. There was also a Saturday member of staff who worked three and a half hours. The owners had six pharmacies and had nine pharmacists working over the premises.

The team members kept their certificates, with copies available. The team received performance reviews which gave them the chance to receive feedback and discuss development needs. The reviews were undertaken by the superintendent pharmacist (SI) who generally worked three days a week. The technician advised she was waiting to start the ACT course, following discussions at her review. Also. one of the dispensers was waiting to commence the technician course after her review.

The SI undertook training with all the team, with a comprehensive induction programme and using the SOPs. And provided the team with copies of SOPs by email and the handbook and their contract. The team members also had access to training modules using the Centre for Pharmacy Postgraduate Education (CPPE) as a resource. Each member of the team had their own login details. And the system kept records of their training. The technician advised some training was mandatory such as the Children's Oral Health, Safeguarding and Risk Management. She advised that as a technician she had to complete level 2 for safeguarding, with other members completing level 1. The dispenser advised that she had recently left, to work in a different setting. But had then returned. She had had an exit interview and raised that she had wanted more variety. The SI advised that others had mentioned this to him. So, he had reviewed the ways of working. And from this month he had restructured the staffing and compiled rotas over three months for all the team to have variety in their work. The team advised they were learning the various roles and shadowed each other in tasks they required to learn, such as the end of month for the prescriptions, managing the Facebook page and the Healthy Living information. The team shared learning on different aspects to keep everyone informed. The team had briefings in the mornings when required. The pharmacy had a 'Training Request form' and these forms

were available for the team to take and fill in if they wanted any specific training or reinforcing of any role. They had to complete if they had previously had training and that they had checked the standard operating procedures (SOPs) for information before asking for additional training. They could also state if they wanted one-to-one training and if they wanted to do additional training outside their contracted hours. They provided buddies for roles to shadow until the team member felt confident to carry out the task.

The pre-registration graduate received training time weekly and undertook training online and joined webinars. The resources for the pre-registration were available. These were all included in the package from the provider, Buttercups, on their on-line portal. The SI advised that plans were in place for the pre-registration graduate to go to one or two of the other branches for a week each to gain different experiences. The trainee MCA followed the sales of medicines protocol when making over-the-counter (OTC) recommendations. She advised the pharmacist if any person asked for information and asked him to speak with them. The managers had a What's App group and shared information between themselves using this for learning.

The pharmacy team members said they could raise concerns about any issues within the pharmacy by speaking to the pharmacists or the SI. They had contact details for the directors and felt comfortable raising any issues. They worked closely together, and the dispenser said they were encouraged to provide feedback about the pharmacy or make suggestions for improvement. The pharmacy team had targets for services such as MURs. These were achievable and done when they met the patient's needs. They were trying to obtain nominations for all the prescriptions to ensure that they would receive the people's prescriptions, especially due to the change in the ordering with the surgeries.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean, secure and suitable for the services provided. And it has suitable arrangements for people to have private conversations with the team.

Inspector's evidence

The pharmacy was clean, tidy and hygienic. The room temperature was comfortable, and the pharmacy well lit. And fitted out to an acceptable standard, with suitable space for dispensing, storing stock and medicines and devices waiting collection. The pharmacy team kept the floor spaces clear to reduce the risk of trip hazards. The sink, benches, shelves and flooring were all clean and the pharmacy maintained a cleaning rota. The dispenser advised that around 5pm each night they had a tidy up time, completing paperwork and housekeeping tasks.

The pharmacy had two rooms used for private conversations. The team used one for preparing paperwork and normally had a member of the team working in it. The team member cleared or covered any paperwork when people required to use the room. And locked the computer screen if unattended, so people could not see any records. The room was easily accessible, and the door generally left open. The team ensured no one went in unattended. And they could see if anyone was waiting to use the consultation room from the counter and dispensary. People used the room mainly for the substance misuse service. The pharmacist used an office for most other private conversations. And the team advised people of the room if they required private conversions. There was always a member of the team covering the counter.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's services are accessible to people. And it displays information about health-related topics. The pharmacy provides its services using a range of safe working practices. And it delivers medicines to peoples' homes with an effective process in place. The pharmacy team members dispense medicines into devices to help people remember to take them correctly. The pharmacy gets it medicines from reputable suppliers. It takes the right action if it receives any alerts that a medicine is no longer safe to use. It generally stores and manages its medicines safely.

Inspector's evidence

The pharmacy, consultation room and pharmacy counter were accessible to all, including patients with mobility difficulties and wheelchairs. There was a touch pad at the entrance for easy access. And there was customer seating available. The pharmacy had a notice board which people could see on entering the pharmacy. This had a display for the flu vaccination service and diabetes. There were some leaflets on a variety of topics for people to take away. The hours of opening were available on the door. And the pharmacy had a practice leaflet but had none display. The pharmacy kept its Facebook page up-to-date. The pharmacy had a defined professional area. And items for sale were mostly healthcare related. Pharmacy only medicines could not be reached by customers.

The team signposted to other healthcare services such as smoking cessation which was not a commissioned service in pharmacies in the area, so they directed people to the appropriate clinics. The pharmacy undertook Medicine Use Reviews (MURs) and the New Medicines service (NMS). It provided flu vaccinations and Travel vaccinations. They provided a walk-in service for the flu vaccinations which was manageable, with most days two pharmacists present in the building. They used Patient Group Directives (PGDs) for sales of norethisterone. The usage of this was monitored. And provided an Emergency Hormonal Contraception (EHC) service. The pharmacy took part in the Community Pharmacy Referral scheme (CPRS) and the NHS Urgent Medicines Supply Advanced Service (NUMSAS). Both were popular and well used, mostly on a Saturday. Often the pharmacy referred people for further treatment. The pharmacy had just started to provide the new service for insomnia, 'Sleepstation'. The pharmacy had written a standard operating procedure and had literature on the topic. Some team members had read and signed this to provide the service. The pharmacy recorded this service on PharmOutcomes.

The pharmacy supplied medicines to around 160 people in multi-compartmental compliance packs to help them take their medicines. It also supplied one home with about 42 people. The pharmacy supplied the home with medicines on a racking system. And the team worked ahead for this to ensure that the home had the racks in place at the home a few days before the home required to start the next cycle. The pharmacy ensured the home had the appropriate Patient information leaflets (PILs). The team made up the community multi-compartmental compliance packs up four weeks at a time. Each person had a box with their packs. Two dispensary members worked on the packs at a time. The team had trackers in place which monitored the progress for the packs. They used 'MDS query forms' for recording any changes to patients' medication for packs which they had developed to assist them with required information. They provided audit records and details of who had authorised the change. The pharmacy kept a diary at the bench for trays for any messages to assist the team members by keeping these together and then actioning. The team kept prescriptions attached to the packs until supply. And

supplied Patient information leaflets (PILs) with each cycle. The team put descriptions on the backing sheets for the medicines. The accuracy checking technician checked most of the compliance packs, on the days she worked. The pharmacy kept a separate near miss log in the room used for the packs to capture any mistakes made during the process.

The pharmacy offered a substance misuse service to several people for methadone and buprenorphine. They generally made up prescriptions with the full amount. This was usually for two weeks but sometimes only one week if that was what the prescriber had prescribed. The pharmacy had a basket for each person in the controlled drugs (CD) cabinet, arranged alphabetically in one cabinet designated for this. Once the pharmacy had made the supply, the team member placed the empty bottle in a named basket, with one for each person, by the CD cabinet. This was just in case there were any queries. And, a team member them had the task to remove the labels and dispose of containers appropriately. They had developed this as on occasions the containers had gone in to the normal waste. And they wanted to ensure they removed all labels to protect confidentiality. They felt this was a task which was better done at set times and not after individual supplies. The pharmacist checked the amounts at each time of supply and entered this and initialled the prescription.

There was a clear audit trail of the dispensing process. The team completed the ‘dispensed by’ and ‘checked by’ boxes which showed who had performed these roles. And a sample of completed prescriptions looked, at found compliance with this process. The team marked the prescriptions with a quad mark and completed appropriately with who had labelled, dispensed, clinically checked and accuracy checked the prescription. The team used appropriate containers to supply medicines. And used clear bags for dispensed CDs and fridge lines so they could check the contents, at the point of hand-out. The team members used CD and fridge stickers on bags and prescriptions to alert the person handing the medication over to add these items. The team highlighted all CD prescriptions to ensure they checked the last dates for supply. The pharmacy team members were aware of the valproate Pregnancy Prevention Programme. They could explain the information they were expected to provide to the ‘patients in the at-risk’ group.

The ordering system for prescriptions for people in the area was being changed in line with the Clinical Commissioning Group (CCG) policy. The team were explaining to people what they would have to do to order their items. The pharmacy offered a delivery service and used an App. They scheduled deliveries for dates. And the driver had a pod which people signed. The pod signature and detail such as delivery time, if the person had signed exempt, if there was a fridge line or CD item included, were all recorded on the system. This provided a robust audit trail. And allowed the team to deal with deliveries efficiently and respond to any queries. The pod synchronised with the pharmacy, so the information was up-to-date. And they could tell people how long their delivery would be. When the pharmacy could not provide the product or quantity prescribed, full patients received an owing slip. And the pharmacy kept one with the original prescription to refer to when dispensing and checking the remaining quantity. The pharmacy contacted prescribers if items were unobtainable at the current time for an alternative.

The pharmacy generally stored medicines in an organised way, within the original manufacturers packaging and at an appropriate temperature. The pharmacy team checked expiry dates on products and had a rota in place to ensure all sections were regularly checked. But there were a few injections which were in white boxes with insufficient details on the outer box such as batch number and expiry date. There was one which the contents were out of date. The others were well in date and all the required information could be put on the container. There were a couple of liquid medicines which did not have the required details on them which had been uncollected items. But the team members clearly marked liquid medication with the date of opening on stock containers which allowed them to

check to ensure the liquid was still suitable for use. The pharmacy had a refrigerator from a recognised supplier. This was appropriate for the volume of medicines requiring storage at such temperatures. The team members recorded temperature readings daily and they checked these to ensure the refrigerator remained within the required temperature range. The pharmacy used recognised wholesalers such as DE, OTC, AAH, Alliance and Norchem. The team used appropriate medicinal waste bins for patient returned medication. These were uplifted regularly. The pharmacy had appropriate denaturing kits for the destruction of CDs.

The pharmacy team were aware of the Pregnancy Prevention Programme for valproate. The team could explain the information they were expected to provide to the “at-risk” group. They had a poster in the dispensary to remind them. An audit had been done. But they did not have any booklets, cards or stickers. The owner had registered the pharmacy with SecurMed for the requirements for the Falsified Medicines Directive (FMD). The pharmacy had the integrated scanners and were ready to implement. The SI advised they were going to trial the system in one of the quieter pharmacies. And then once they had finalised a standard operating procedure they would implement in the other pharmacies. They anticipated this would be in the next few months. The pharmacy had a process to receive drug safety alerts and recalls. The SI sent these to all branches for attention. The team actioned these and kept records of the action taken.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs for the pharmacy services it provides. There are provisions in place to maintain people's privacy.

Inspector's evidence

The pharmacy team members had access to a range of up to date reference sources, including the British National Formulary (BNF). They used the internet as an additional resource for information such as the Electronic Medicines Compendium (EMC) for patient information leaflets (PILs). The pharmacy had measuring equipment available, including equipment for counting loose tablets and capsules. And a range of clean, crown-stamped measures. The pharmacy kept measures for methadone in a separate basket, but they were not marked. A team member advised the rubber bands had deteriorated and they would mark with colour to indicate the difference.

The pharmacy stored medication waiting collection on shelves where no confidential details could be observed by people. The team filed these in boxes in a retrieval system out of view, keeping details private. The team used the NHS smart card system to access to people's records. Team members had cards with access permitted for their roles. The counter members could only access the system for electronic prescriptions. The team used cordless phones for private conversations. The computer screens in the dispensary were out of view of the public.

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.