General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: D.A. Tubb Ltd., Newton Hill, Newton Ferrers, PLYMOUTH, Devon, PL8 1AB

Pharmacy reference: 1030853

Type of pharmacy: Community

Date of inspection: 01/08/2019

Pharmacy context

The pharmacy is in the small village of Newton Ferrers. It sells over-the-counter medicines and dispenses NHS and private prescriptions. The pharmacy team offers advice to people about minor illnesses and long-term conditions. The pharmacy offers services including Medicines Use Reviews (MURs), flu vaccinations and the NHS New Medicines Service (NMS). It also supplies medicines in multi-compartmental medicines devices 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 identifies and manages its risks appropriately. Team members record their errors and review them, generating clear actions to improve safety. They learn from their mistakes and make changes to stop them from happening again. The pharmacy has written procedures in place for the work it does. The pharmacy asks people for their views and acts appropriately on the feedback. The pharmacy has adequate insurance to cover its services. The pharmacy keeps the records required by law. The pharmacy keeps people's private information safe and explains how it will be used. Pharmacy team members know how to protect the safety of vulnerable people.

Inspector's evidence

The pharmacy had adequate processes in place to manage and reduce its risks. Near misses were routinely recorded and entries in the near miss log contained a reflection on why the error occurred and actions taken to prevent a reoccurrence. Errors were discussed by the small team at the time of occurrence. Stock was moved or highlighted when it had been subject to an error. For instance, amlodipine and atorvastatin were clearly separated. Dispensing incidents were reported on the National Reporting and Learning System (NRLS). These reports contained a more detailed analysis of the cause of the error. Following a dispensing incident where the wrong formulation of inhaler had been dispensed, shelf edge alerts had been placed at the location of the affected product.

All near misses and dispensing incidents were formally reviewed on a quarterly basis. The outcomes of the reviews and associated actions were shared with all team members on an individual basis. Recent actions included to review the location of stock that had been dispensed incorrectly and apply shelf edge alerts where appropriate, particularly for look-alike, sound-alike drugs.

The responsible pharmacist (RP), who was also the superintendent pharmacist, described how, before implementing a new service, she would ensure the pharmacy would able to accommodate the work, and that it would be applicable to the local population. She would review staffing levels to ensure provision of the service could be maintained and would check that she and her staff had access to the appropriate tools and training to provide the service.

Standard operating procedures (SOPs) were up to date and had been recently reviewed. A dispenser could describe the activities that could not be undertaken in the absence of the RP. Staff had clear lines of accountabilities and were clear on their job role.

Feedback was obtained by a yearly community pharmacy patient questionnaire (CPPQ) survey. 100% of respondents to the most recent survey had rated the service provided by the pharmacy as very good or excellent. A complaints procedure was in place and was kept in the SOP folder. Following feedback that people were not always aware that there was a consultation room for private conversations, the RP now proactively offered its use to people.

Records of the RP were held on paper and were generally in order. But the RP did not always sign out if she knew she was working the following day. There had been no entries made since 27 July 2019 since a locum pharmacist had signed out. The correct RP certificate was displayed. Controlled drug (CD) registers were maintained appropriately. But one bound register had the first few pages started with

Sevredol 10mg tablets. These tablets were then destroyed and the register was reused for MST 5mg tablets. Balance checks were completed regularly. A random balance check of MST Continus 5mg tablets was accurate. Patient returned CDs were recorded in a separate register and were destroyed promptly. Records of private prescriptions and emergency supplies were held on in a book and were in order. Records of emergency supplies contained the nature of the emergency. Specials records were maintained, and certificates of conformity had all required details completed.

All staff had completed training on information governance and general data protection regulations and had signed the associated policies. Patient data and confidential waste was dealt with in a secure manner to protect privacy and no confidential information was visible from customer areas. A privacy policy and a fair data use statement were available and given to people as needed. NHS smart cards were used appropriately. Verbal consent was obtained before summary care records were accessed.

All staff were trained to an appropriate level on safeguarding. The RP had completed the Centre for Postgraduate Pharmacy Education (CPPE) level 2 safeguarding training, and the remaining staff had read the SOP. Local contacts were available and staff were aware of signs of concerns requiring escalation to other agencies.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough staff. Team members are appropriately trained for their roles and they keep their skills and knowledge up to date. They receive time to learn during working hours. Team members are confident to suggest and makes changes to improve their services. They communicate well with each other.

Inspector's evidence

Staffing levels were adequate on the day of the inspection and consisted of the RP, who was also the superintendent pharmacist and an NVQ2 trained dispenser. There was also a part time dispenser and a medicines counter assistant who were not working on the day of the inspection. The small team clearly had a good rapport and felt they could manage the workload with no undue stress and pressure.

Staff worked set days and hours. Planned and unplanned absences were covered by part-time staff increasing their hours or rearranging shifts. A regular locum covered the RP's days off and holidays. There was also a retired pharmacist living in the village who could be called on in an emergency.

The pharmacy team received protected time to learn during working hours. Resources accessed included CPPE packages and revised SOPs. The dispenser said that she received regular feedback on her performance from the RP. She was seen to offer appropriate advice when selling medicines over the counter and were observed referring to the RP when additional information was required.

The dispenser said that she felt able to raise concerns and give feedback to the RP, who she found to be receptive to ideas and suggestions. Team members were aware of the escalation process for concerns and a whistleblowing policy was in place.

The pharmacy did have targets that they were required to meet. The RP said that she would only undertake services such as MURs that were clinically appropriate.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy provides a safe, secure and professional environment for people to receive healthcare. It has a consultation room for private conversations. It is appropriately secured to prevent unauthorised access.

Inspector's evidence

The pharmacy was located at in a small village at the bottom of a steep hill. It was accessed by a set of steps and was not wheelchair accessible. A well-stocked retail area led to the small dispensary. A room to the rear of the pharmacy was used to prepare multi-compartment medicines devices. This room was also used as a consultation room for private conversations. It was soundproof but as completed prescriptions were stored on the shelves, there was potential for people to view other people's private information.

The small dispensary was well organised and tidy. Stock was neatly stored on shelves. No stock or prescriptions were stored on the floor, and there were dedicated areas for dispensing and checking. Prescriptions awaiting collection were stored in a retrieval system.

An upstairs room was used to store excess stock and archived paperwork. It was not accessible to the public. No medicines were stored upstairs, apart from patient returns. The room was appropriately secured.

Cleaning was undertaken regularly by the pharmacy team. The pharmacy was clean on the day of the inspection. The temperature and lighting were appropriate for the storage and assembly of medicines.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy is not easy to enter for people using wheelchairs or with mobility problems. But team members serve people at the door to ensure the pharmacy's services can be accessed by everyone. The pharmacy supplies medicines safely and gives additional advice to people receiving high-risk medicines. But it does not usually make a record of this advice which makes it difficult to show that it has been given. The pharmacy obtains its medicines from reputable suppliers. It stores them securely and regularly checks that they are still suitable for supply. The pharmacy deals with medicines returned by people appropriately.

Inspector's evidence

The pharmacy was located at the bottom of a large hill in the village. There were a handful of parking spaces in the pub opposite. The pharmacy was entered by a flight of steps, making it inaccessible to those in wheelchairs or with mobility issues. But the RP had placed a sign next to the entrance encouraging people to knock or ring the bell if they required assistance. The location of the steps and the dispensary meant that the pharmacy team could easily see if someone was entering the pharmacy. The RP said that she or the dispenser would happily serve at the door if needed. The pharmacy could produce large print labels for those with impaired vision. No hearing loop was available but the dispenser said she would speak loudly and clearly or use pen and paper when communicating with a person with impaired hearing.

The dispenser explained that if a person requested a service not available at the pharmacy, she would refer them to a nearby pharmacy, phoning ahead to ensure it could be provided there. A range of leaflets advertising local services were available. Details of local organisations offering health-related services were accessed online.

The RP felt that she was very involved in the community. She worked well with the local primary school and ran termly healthy living events. Local topics had included the need for good hydration and child oral health. She recognised that the majority of her users were elderly and stocked products appropriate for this group.

Baskets were used to store prescriptions and medicines to prevent transfer between patients as well as organise the workload. There were designated areas to dispense walk-in prescriptions and owings. The labels of dispensed items were initialled when dispensed and checked. The RP usually dispensed and self-checked walk-in prescriptions. She tried to ensure that she took a mental break between each step to reduce the risk of errors.

Coloured labels were used to highlight fridge items and CDs including those in schedule 3 and 4. Prescriptions containing CDs were also highlighted along the bottom. Prescriptions were labelled if they contained items that may require additional advice from the RP, such as high-risk medicines. Blood levels and dosages for high-risk medicines were checked and additional counselling and support materials were offered to the patient. Records of these conversations were not routinely made on the PMR.

The pharmacy had completed the audit of people at risk of becoming pregnant whilst taking sodium

valproate as part of the Valproate Pregnancy Prevention Programme. Stickers were available for staff to highlight the risks of pregnancy to women receiving prescriptions for valproate. Information booklets and cards were available to be given to eligible women.

The process for the dispensing of multi-compartment medicines devices provided to four people living in their own homes was acceptable. Each pack had an identifier on the front, and dispensed and checked signatures were available, along with a description of tablets. Patient information leaflets were supplied at each dispensing, or with the first pack of four in the case of weekly supply. 'When required' medicines were dispensed in boxes and the dispenser was aware of what could and could not be placed in trays. A record of any changes made was kept on the patient information sheet, which was available for the pharmacist during the checking process.

The pharmacy offered a delivery service one morning every two weeks. This was carried out by a dispenser. Outside of the formal delivery time, team members occasionally delivered prescriptions to housebound people who needed it. Records were kept of all deliveries made.

Stock was obtained from reputable sources including Alliance, and AAH. The pharmacy had the hardware and software to be compliant with the Falsified Medicines Directive but were not currently scanning compliant packs of medicines. The RP said that she was waiting for more compliant packs to be in the supply chain on the advice of the NPA. Stock was date-checked every six months. Short dated items were written in a book. Spot checks revealed no date expired stock or mixed batches.

The pharmacy fridge was clean, tidy and well organised. Records of temperatures were maintained. The maximum and minimum temperatures were within the required range of two to eight degrees Celsius. Staff were aware of the steps taken if the fridge temperature was found to be out of range, which was to monitor every 30 minutes until back in range. CDs were stored in accordance with legal requirements. Out of date and patient returned CDs were clearly segregated. Patient returned CDs were recorded in a register and destroyed with a witness with two signatures were recorded. Denaturing kits were available for safe destruction of CDs.

Patient returned medication was dealt with appropriately, and a hazardous waste bin was in use. Patient details were removed from returned medicines to protect people's confidentiality. Due to the lack of space, the pharmacy arranged for additional collections of pharmaceutical waste as needed.

Drug recalls were dealt with promptly and were annotated with details of the person actioning and the outcome. A log was kept of all recalls received.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy uses a range of appropriate equipment and facilities to provide its services. It keeps these clean and well maintained.

Inspector's evidence

Validated crown-stamped measures were available for liquids. A range of clean tablet and capsule counters were present, with a separate triangle clearly marked for cytotoxics. Reference sources were available and the pharmacy had online access to online materials for the most up to date information.

The dispensary sink was in the consultation room and was in good working order. All equipment including the dispensary fridge was in good working order and PAT test stickers were visible and were in date.

Dispensed prescriptions were stored in a retrieval system with the corresponding bagged items stored in numbered boxes in the dispensary, out of sight of customers. Computers were positioned so that no information could be seen by customers, and phone calls were taken away from public areas.

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.