General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Andrew D Byers, The Pharmacy, High Street, MORETON-IN-MARSH, Gloucestershire, GL56 0AL

Pharmacy reference: 1031580

Type of pharmacy: Community

Date of inspection: 27/02/2020

Pharmacy context

This is a community pharmacy in the centre of Moreton-in-Marsh, a popular market town in the Cotswolds. A wide variety of people use the pharmacy. It is busy and open every day of the week. The pharmacy dispenses NHS and private prescriptions and sells over-the-counter medicines as well as several other items. It also supplies several medicines in multi-compartment compliance aids to help vulnerable people in their own homes to take their medicines.

Overall inspection outcome

Standards not all met

Required Action: Improvement Action Plan

Follow this link to find out what the inspections possible outcomes mean

Summary of notable practice for each principle

Principle	Principle finding	Exception standard reference	Notable practice	Why
1. Governance	Standards not all met	1.6	Standard not met	The pharmacy does not keep all the up-to-date records that it must by law.
		1.7	Standard not met	The pharmacy keeps people's private information in an easily accessible, unlocked room.
2. Staff	Standards not all met	2.1	Standard not met	The pharmacy does not have enough suitably qualified staff to manage its workload safely.
		2.2	Standard not met	Some team members are doing tasks for which they are not trained in contravention of the published, minimum requirements of the General Pharmaceutical Council.
		2.4	Standard not met	The team members do not do any regular learning and they do not have any appraisals. This means that their knowledge may not be up to date and any gaps in their skills and knowledge may not be identified.
3. Premises	Standards not all met	3.1	Standard not met	Not all areas of the pharmacy look professional. In particular, the room that is signposted as a consultation room is dirty, untidy and cluttered.
		3.4	Standard not met	The pharmacy needs to have better security to some areas.
4. Services, including medicines management	Standards not all met	4.3	Standard not met	The pharmacy does not store all its medicines safely.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance **Standards not all met**

Summary findings

The pharmacy's working practices are mainly satisfactory. But, it keeps people's private information in an easily accessible, unlocked room. And, not all the team members know about the changes to the protection of people's personal information. The pharmacy generally keeps the up-to-date records that it must by law but not those for the recording of private prescriptions. It is appropriately insured to protect people if things go wrong. But, the team members could be better at recording and learning from mistakes to prevent them from happening again.

Inspector's evidence

The pharmacy team identified and managed most risks. Any dispensing error or incident was recorded, reviewed and appropriately managed. The last error had been in October 2019 where the wrong strength of prednisolone had been given to a patient. An incident report had been completed and as a result of the error, the two strengths, 1mg and 5mg, had been placed on separate shelves. Few near miss errors were recorded. Those that were recorded had insufficient information to allow any useful analysis. No learning points or actions taken to reduce the likelihood of similar recurrences were documented. General trends could be identified but the log was not reviewed and so these were not identified.

The main dispensary was limited in size with one small dispensing bench. The staff did their best to manage this space but there was no clear assembly area and checking area. Staffing levels (see further under principle 2) meant that the pharmacist did have to self-check items. He was aware of the risk of this and endeavoured to have a mental break between the assembly process and the checking process. Baskets were used but, different colours did not distinguish different prescriptions so it was not easy to prioritise the workload. A separate room next door to the main dispensary, was used for the assembly and checking of the multi-compartment compliance aids. This was tidy and organised but not kept locked (see below and further under principles 3 and 4). There was a clear audit trail of the dispensing process and all the 'dispensed by' and 'checked by' boxes on the labels examined had been initialled.

Up-to-date and signed standard operating procedures (SOPs) were in place and these were reviewed every two years by the superintendent pharmacist. The roles and responsibilities were set out in the SOPs and the staff were clear about their roles. But, two staff members who did the assembly of the multi-compartment compliance trays were not enrolled on an accredited dispensing assistant course (see further under principle 2). A medicine counter assistant said that she would refer all medicine sale requests for patients who were also taking prescribed medicines, to the pharmacist. She was aware of 'prescription only medicine' (POM) to 'pharmacy only medicine' (P) switches, such as omeprazole and referred requests for these to the pharmacist.

The pharmacy completed an annual community pharmacy patient questionnaire (CPPQ). In the 2019 survey, 83% of people who completed the questionnaire rated the pharmacy as excellent or very good overall. There had been some feedback about having somewhere private to talk. The pharmacy did have a signposted consultation room but the signage was not prominent. The room was also used as an office. It was unlocked and did not present a professional pharmacy image (see further under principle 3).

Public liability and professional indemnity insurance provided by the National Pharmacy Association (NPA) and valid until 31 May 2020, was in place. The responsible pharmacist log, controlled drug (CD) records, including patient-returns, emergency supply records, specials records, fridge temperature records and date checking records were in order. Private prescriptions were recorded electronically. Many of these did not include the details of the prescriber as required by law.

The pharmacist and accuracy checking technician (ACT) were aware information governance (IG) issues but the pharmacy's policy could not be located at the time of the inspection. The pharmacist and ACT had completed training on the general data protection regulations (GDPR). However, the medicine counter staff were not sure either about the IG policy or about GDPR. The pharmacy computers, which were not visible to the customers, were password protected. Patient confidential information was not stored securely in the room that was used for the assembly of the compliance aids. The room was in constant use and the door was seen to be left open. Confidential waste paper information was collected for appropriate disposal. No conversations could be overheard in the room that was signposted as a consultation room.

Not all the staff understood the meaning of 'safeguarding'. The pharmacist and ACT had completed the Centre for Pharmacy Postgraduate Education (CPPE) module on safeguarding and 'Dementia Friends' training. Local telephone numbers were available to escalate any concerns relating to both children and adults.

Principle 2 - Staffing **Standards not all met**

Summary findings

The pharmacy does not have enough suitably qualified staff to manage its workload safely. And, the pharmacy has inadequate procedures in place when team members are off sick or on holiday. Some team members are doing tasks for which they are not trained. This is in contravention of the published, minimum training requirements of the General Pharmaceutical Council. The team members do not do any regular learning and they do not have any appraisals. This means that their knowledge may not be up to date and any gaps in their skills and knowledge may not be identified.

Inspector's evidence

The pharmacy was in the centre of Moreton-in-Marsh. It was busy and open every day of the week. They mainly dispensed NHS prescriptions. Several domiciliary patients received their medicines in compliance aids.

The current staffing profile was two part-time pharmacists (working three and four days respectively), one full-time accuracy checking technician (ACT), 5 full-time medicine counter assistants (MCAs) and one part-time MCA. Two of the MCA's were responsible for the assembly of the compliance aids. One of these had been enrolled on an accredited dispensing course some time ago but said that she had not received any support to complete this and so the course had lapsed. The other staff member had received no dispensing training. Both these team members had been working in the compliance aid room for a long time. This is contrary to the minimum training requirements of the General Pharmaceutical Council (GPhC). The staffing profile also meant that the pharmacist sometimes had no help in the main dispensary because the ACT was occupied with the checking of the compliance aids. In addition, no additional support was provided when the ACT was off sick or on holiday. She said that she tried to get ahead of the workload prior to any planned holiday. The ACT and pharmacist said that the pharmacy was not behind with their work schedule largely because of the long opening hours.

The pharmacy staff received no regular on-going learning. There were no formal appraisals and so any gaps in their skills and knowledge were not identified. The pharmacist and ACT did do regular learning and this was documented on their continuing professional development (CPD) records. There were no regular staff meetings and not all the staff were aware of the pharmacy's whistle-blowing policy. The pharmacist said that he had no time to do any advanced NHS services such as Medicines Use Reviews (MURs) and no targets or incentives were set for these.

Principle 3 - Premises **Standards not all met**

Summary findings

Not all areas of the pharmacy look professional. In particular, the room that is signposted as a consultation room is dirty, untidy and cluttered. And, the pharmacy needs to have better security to some areas.

Inspector's evidence

The retail area pharmacy was well laid out and presented a professional image. The main dispensary was small with one work bench but the staff did their best to keep this area organised. There was a swing gate to the main dispensary. The dispensary was seen to be left unoccupied on occasions.

The room that was used for the assembly and checking of the compliance aids was organised. There was also just one bench dispensing bench in here but shelves were utilised to store the compliance aids in order to keep the bench as clear as possible. This room was in constant use and was seen to be kept open.

Not all areas of the pharmacy were clean and well maintained. In particular, the room signposted as the consultation room was cluttered, untidy and dirty. This was supposed to be a patient-facing room and did not present a professional pharmacy image. In addition, the signage on the door did not look professional. The room was said to be mainly used as an office. It was unlocked. Some of the upstairs areas in the pharmacy needed repair and routine maintenance.

The pharmacy computer screens were not visible to customers. The telephone was cordless and all sensitive calls were taken out of earshot. The temperature in the pharmacy was below 25 degrees centigrade. There was good lighting throughout. Many items for sale were healthcare related but several other items were also sold.

Principle 4 - Services **Standards not all met**

Summary findings

The pharmacy offers few services and some people with specific mobility needs may have difficulty entering the pharmacy. It generally manages the services it does offer, effectively, to make sure that they are delivered safely. The team members make sure that people have the information that they need to take their medicines properly. But, because the pharmacy is not doing some routine counselling services, it may not be identifying any problems that people may be having. The pharmacy gets is medicines from appropriate sources but it does not store them all safely. The team members make sure that people only get medicines or devices that are safe but there could be a better audit trail demonstrating this.

Inspector's evidence

There was wheelchair access to the pharmacy but not to the room signposted as a consultation room because of a step up. And, there was no bell on the front door of the pharmacy alerting staff to anyone who may need assistance entering the pharmacy. The staff could access an electronic translation application for use by non-English speakers. The pharmacy was located in a popular tourist town. They could print large labels for sight-impaired patients.

No advanced or enhanced NHS services, except a few supervised substance misuse patients, were currently being offered by the pharmacy despite it being the only pharmacy in the town.

Several domiciliary patients received their medicines in compliance aids. These were prepared in a separate room. The bench space was small for the workload but the room was organised. The compliance aids were mainly assembled on a four-week rolling basis and evenly distributed throughout the week to manage the workload. There were dedicated folders for these patients where all the relevant information such as hospital discharge sheets and changes in dose were kept. But, there was no a concise, chronological audit of changes for easy reference by the ACT or pharmacist who were checking the compliance aids. The ACT said that she would introduce this. The assembled compliance aids were stored tidily on dedicated shelves. They were also divided by colour into male and female patients to reduce the risk of errors with married people of the same surname. But, as mentioned under principle 1 and 3, the door to this room was seen to be kept open. Procedures were in place to ensure that all patients who had their medicines in compliance aids and were prescribed high-risk drugs, were having the required blood tests.

There was a good audit trail for all items ordered on behalf of patients by the pharmacy and for all items dispensed by the pharmacy. The pharmacist routinely counselled patients prescribed high-risk drugs such as warfarin and lithium. International normalised ratios were asked about. The pharmacist also counselled patients prescribed amongst others, antibiotics, new drugs and any changes. CDs and insulin were packed in clear bags and these were checked with the patient on hand-out. The ACT and pharmacist were aware of the sodium valproate guidance relating to the pregnancy protection programme but not the staff working on the medicine counter were. The pharmacy currently had no ‘at risk’ patients.

All prescriptions containing potential drug interactions, changes in dose or new drugs were highlighted to the pharmacist. Signatures were obtained indicating the safe delivery of all medicines and owing slips

were used for any items owed to patients. Potential non-adherence or other issues could go undetected because the pharmacy was currently not doing any routine Medicine Use Reviews (MURs) or New Medicine Service (NMS) reviews.

Medicines and medical devices were obtained from AAH, Alliance Healthcare and Zecare. Specials were obtained from IPS Specials. Invoices for all these suppliers were available. The pharmacy had no operational scanner to check for falsified medicines as required by the Falsified Medicines Directive (FMD). CDs were stored in two safes. There were several patient-returned CDs and out-of-date CDs. These were clearly labelled and separated from usable stock but were occupying valuable space. Appropriate destruction kits were on the premises. Fridge lines were correctly stored with electronic records. Date checking procedures were in place with signatures recording who had undertaken the task. Designated bins were available for medicine waste and used. There was a separate bin for cytotoxic and cytostatic substances and a list of such substances that should be treated as hazardous for waste purposes.

There was a procedure for dealing with concerns about medicines and medical devices. Drug alerts were received electronically, printed off and the stock checked. They were signed and dated by the person checking the alert. The pharmacy had received an alert on 5 February 2020 about ranitidine tablets. The pharmacy had none in stock but this was not was recorded.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the appropriate equipment for the services it provides. And, the team members make sure that it is clean and fit-for-purpose.

Inspector's evidence

The pharmacy used British Standard crown-stamped conical measures (10 - 100ml). There were several tablet-counting triangles. These were cleaned with each use. There were up-to-date reference books, including the British National Formulary (BNF) 78 and the 2019/2020 Children's BNF. There was access to the internet.
The fridge was in good working order and maximum and minimum temperatures were recorded daily. The pharmacy computers were password protected and not visible to the public. There was a cordless telephone and any sensitive calls were taken in the consultation room or out of earshot. Confidential waste information was collected for appropriate disposal.

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.