General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: H.J. Everett (Chemist) Ltd., 28 The Square, Titchfield, FAREHAM, Hampshire, PO14 4RU

Pharmacy reference: 1031706

Type of pharmacy: Community

Date of inspection: 02/05/2019

Pharmacy context

This is a community pharmacy located within the village of Titchfield in Hampshire. Mainly older people use the pharmacy's services. The pharmacy dispenses NHS and private prescriptions. It provides some services such as Medicines Use Reviews (MURs) and the New Medicine Service (NMS). And, it supplies some people with their medicines inside multi-compartment compliance packs, if they find it difficult to take their medicines on time.

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	3.5	Good practice	The recent re-fit along with the design and layout of the dispensary and pharmacy has ensured the safe provision of healthcare
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 manages some risks effectively. It has written instructions to help with this. But, the pharmacy team has not read them. This increases the chance of mistakes happening. Pharmacy team members deal with their mistakes responsibly. But, they are not recording or reviewing all of them. This could mean that they may be missing opportunities to spot patterns and prevent similar mistakes happening in future. And, the pharmacy does not display information about how people can complain about the pharmacy. This makes it harder for people to know who to raise concerns with and could mean that the pharmacy misses opportunities to improve its services. The pharmacy's team members generally understand how they can protect the welfare of vulnerable people. But, some of the pharmacy's records are not always kept in accordance with the law. This means that the team may not have all the information needed if problems or queries arise.

Inspector's evidence

The pharmacy was clear of clutter and organised. There was enough space for prescriptions to be dispensed safely. Staff described assembling Monitored Dosage Systems (MDS) in a segregated space. This helped prevent errors from interruptions and distractions. The dispensary was designed in a way that allowed the work to flow smoothly and this was in conjunction with the space available. This meant that the different stages occurred in a circular motion and involved segregated sections for the receipt of prescriptions, processing, dispensing as well as the final check by the Responsible Pharmacist (RP). This helped reduce the likelihood of errors occurring.

Staff had assisted in rearranging the dispensary after the pharmacy's refit. They tried to ensure that previously seen common errors could be minimised by separating the medicines involved. This included segregating tablets and capsules of some medicines, placing bendroflumethiazide 2.5mg tablets with other fast-moving medicines and the 5mg strength in a drawer as well as placing caution notes in front of some medicines as an additional visual alert.

The RP explained that during the pharmacy's refurbishment, the team were operating out of a portacabin and had only moved back into the premises within the last six weeks. Before their move, according to the RP, near misses were being recorded. This had not been occurring recently and previous records were not seen. Near misses were not being formally and regularly reviewed at the point of inspection. An annual patient safety report was seen from 2018 that had been completed. However, the key learning points were missing from this.

The RP handled incidents. The process here involved rectifying the situation, apologising, identifying the root cause, making the team aware, documenting details and reporting this to the superintendent pharmacist. Documented details of previous incidents were seen. There was no information on display about the pharmacy's complaints procedure.

The pharmacy's head office had implemented documented Standard Operating Procedures (SOPs) to support the supply of its services. These were from the National Pharmacy Association (NPA) and from December 2018. At the point of inspection, staff had not read and signed the SOPs.

Some team members could identify signs of concern to safeguard vulnerable people. Some staff required prompting but mentioned people with dementia. They informed the RP in the event of a

concern and had all read relevant information as part of their training. The pharmacist was trained to level 2 via the Centre for Pharmacy Postgraduate Education (CPPE). Local contact details for the safeguarding agencies were present and a protocol for the team to follow was on the wall in staff areas.

There was no confidential material left within areas that faced the public. The team shredded confidential waste. Bagged prescriptions awaiting collection were stored in a location that prevented sensitive information being visible from the retail area. Staff were trained on the EU General Data Protection Regulation (GDPR). This was through information that they received from their head office and from the RP. There was no information on display to inform people about how their privacy was maintained.

The correct RP notice was on display. This provided details of the pharmacist in charge of operational activities. A complete audit trail for the receipt and destruction of returned CDs was maintained. The team checked the minimum and maximum temperature of the fridge to ensure medicines were appropriately stored here. Daily records were kept verifying this. Records of supplies made against private prescriptions, for unlicensed medicines and a sample of registers checked for controlled drugs (CDs) were maintained in line with statutory requirements. On randomly selecting two CDs held in the cabinet, only the quantity of of one of them matched the balance recorded in the register. The RP confirmed by email, immediately following the inspection that the balance for the other one had been reconciled.

Most records of emergency supplies were documented with the nature of the emergency, but the odd record was seen with this information missing. There were gaps within the electronic RP record where pharmacists had not recorded the time that their responsibility ceased. The pharmacy's professional indemnity insurance was through the NPA and due for renewal after 31 May 2019.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough staff to manage its workload safely. The pharmacy's team members are trained well. They understand their roles and responsibilities. And, they keep their skills and knowledge up to date by completing regular training.

Inspector's evidence

The pharmacy dispensed 5,500 prescription items every month with 32 people receiving their medicines inside multi-compartment compliance packs and two people with instalment prescriptions. The staffing profile included a regular pharmacist, two dispensing assistants, one of whom was undertaking accredited training for accuracy checking, a pharmacy technician, four medicines counter assistants (MCAs) and four delivery drivers who were shared between the pharmacy's other branches. All staff were trained through accredited routes. Their certificates of qualifications obtained were seen to verify this. The team wore name badges.

Staff knew which activities were permissible in the absence of the RP, they used a range of questions to obtain relevant information before selling over-the-counter (OTC) medicines and if they were unsure, details were brought to the attention of the RP. The team held sufficient knowledge of OTC medicines to sell these safely.

Staff completed regular online training through virtual outcomes and received literature or presentations from different pharmaceutical company sales representatives. The team regularly took instruction from the RP and were provided with relevant information from their head office. Their progress was checked annually through formal appraisals. As they were a small team, they communicated verbally and regularly discussed details between them.

In addition to the Essential Services, the pharmacy also provided emergency hormonal contraception (EHC), the NHS Urgent Medicine Supply Advanced Service (NUMSAS), the Pharmacy Urgent Repeat Medicines Service (PURM) and 'Quit 4 Life', the Hampshire NHS stop smoking service. Last season, the pharmacy administered influenza vaccinations under Patient Group Directions (PGDs). The pharmacist described a target to achieve two MURs a day. This was described as manageable and there was no pressure applied to achieve.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy's premises are clean, secure and provide a professional environment to deliver its services.

Inspector's evidence

The premises consisted of a medium-sized retail area and dispensary on the left-hand side of the retail space. There was also another segregated dispensary to prepare multi-compartment compliance packs, a staff kitchenette area and WC facilities. The pharmacy was suitably lit and appropriately ventilated. It had recently undergone an extensive refurbishment. All areas were clean, well presented and professional in appearance.

There was also a second entry point from the dispensary into the retail space that allowed the RP to easily come out and counsel people. This tied in with the pharmacy’s workflow design, as mentioned in Principle 1. Pharmacy-only (P) medicines were stored behind the front counter. Staff were always within the vicinity to help prevent the self-selection of these medicines.

Two signposted consultation rooms were available to provide services and private conversations. Both were kept unlocked and were of a suitable size for the services provided. There was no confidential information present or easily accessible from either room.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy sources, stores and manages most of its medicines appropriately. Team members make checks to ensure that medicines are not supplied beyond their expiry date. But, the pharmacy has no up-to-date written details to demonstrate this. So, the team may not always be able to show that all stock is safe to use. In general, the pharmacy provides its services safely and effectively. But, it doesn't always identify all people on high-risk medicines such as blood-thinning medicines. This may mean that it is missing opportunities to ensure that people are taking their medicines safely.

Inspector's evidence

The pharmacy's front entrance was sloped from the street. This, along with the wide aisles and clear, open space inside the premises meant that people needing wheelchair access could easily use the pharmacy's services. There was seating available and this allowed around four people to wait for their prescriptions if needed. There were some car parking spaces outside the pharmacy. The team described facing people who were partially deaf so that they could lip read. Staff explained details verbally and read instructions to people who were partially sighted. There were some leaflets available for people to access information about other local services. Staff used their own knowledge as well as documented details to help signpost people to other local organisations.

PGD paperwork for all the services were present and signed by the authorised pharmacist. The pharmacy team used baskets to hold each prescription and associated medicines. This prevented any inadvertent transfer. Staff used a dispensing audit trail to verify their involvement in processes. This was through a facility on generated labels.

Prescriptions requiring collection were held within an alphabetical retrieval system. Fridge items and CDs (Schedules 2 and 3) were identified. Schedule 4 CDs were not highlighted. Counter staff were somewhat aware that these prescriptions were only valid for a reduced amount of time. Uncollected medicines were checked and removed every three months.

Multi-compartment compliance packs were supplied to people who found managing their medicines difficult. The RP completed an initial assessment to determine people's suitability for these packs. The team ordered prescriptions on behalf of people with the packs, when these were received, details on prescriptions were cross-referenced against individual records to help identify changes or missing items. Queries were checked with the prescriber and audit trails were maintained to demonstrate this. Descriptions of medicines within the packs were provided. Patient Information Leaflets (PILs) were routinely supplied. All medicines included in the packs were de-blistered and removed from their outer packaging. Trays were not left unsealed overnight. Some people received finasteride inside trays. Staff were aware of handling precautions associated with this medicine but were unsure if people receiving this inside the packs had carers. Mid-cycle changes involved the packs being retrieved, amended, re-checked and re-supplied.

Medicines were delivered to people. The team maintained audit trails to demonstrate when and where medicines were delivered. This included identifying CDs and fridge items. The driver obtained people's signatures when medicines were delivered and brought back failed deliveries. They left notes to inform people about the attempt made and did not leave medicines unattended unless, for example, a key code was provided.

Staff were aware of risks associated with valproate. There was literature present to provide to people if needed. An audit had been completed to identify people in the at-risk group. The RP explained that no prescriptions for people in the at-risk group had been seen.

Prescriptions for higher-risk medicines were not marked in any way to enable pharmacist intervention, counselling or checking of relevant parameters to routinely occur. The RP explained that people receiving these medicines from the pharmacy were stable and details were checked during MURs. People prescribed warfarin were not routinely asked about their International Normalised Ratio (INR) level. There were no details seen documented about relevant parameters.

The company used the Pharmacy Buyer system to obtain medicines and medical devices. These were sourced from licensed wholesalers such as Colorama, AAH, Alliance Healthcare, OTC Direct and Doncaster. Unlicensed medicines were obtained through Quantum Specials. The team were complying with the European Falsified Medicines Directive (FMD). The pharmacy was registered with SecurMed, the pharmacy system had been updated and relevant equipment was present. Staff were provided with information and literature about the process, they took instruction from the RP and were aware of the processes involved as the pharmacist had initially demonstrated this to them.

Medicines were stored in an organised manner. Counter staff checked OTC medicines for expiry regularly. There was no schedule being used to demonstrate this process at the point of inspection. A book and a schedule were used by dispensary staff to check prescription-only medicines for expiry. This process occurred every three months. However, the schedule was not up to date and details were last seen marked from January 2019. Short-dated medicines were identified using a highlighter pen. There were no date-expired medicines or mixed batches seen. Liquid medicines were marked with the date that they were opened. Mirtazapine tablets were seen stored outside of their original container and not marked with all relevant details. The expiry date and batch number were missing. CDs were stored under safe custody. The key to the cabinet was maintained in a manner that prevented unauthorised access during the day and overnight.

Once accepted, the team stored returned medicines requiring disposal within appropriate receptacles. People bringing back sharps for disposal were referred to the local council. Returned CDs were brought to the attention of the RP with relevant details entered into a CD returns register.

Drug alerts were received by email and through invoices from wholesalers. The process involved checking for stock and acting as necessary. An audit trail was available to verify this.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the appropriate equipment and facilities to provide its services safely.

Inspector's evidence

The pharmacy was equipped with current versions of reference sources. Computer terminals were positioned in a way that prevented unauthorised access. A shredder assisted in disposing of confidential waste. Staff used their own NHS smart cards to access electronic prescriptions. They either took the cards home overnight or stored them securely.

Clean, crown stamped conical measures were present for liquid medicines. Counting triangles were available. This included a separate one for cytotoxic medicines. The team could also use a tablet counting machine. This was calibrated before use.

The dispensary sink used to reconstitute medicines was clean. There was hot and cold running water available as well as hand wash present. The fridge was maintained at appropriate temperatures for the storage of medicines. The CD cabinet was secured in line with legal requirements. Staff could use lockers to store their personal belongings.

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.