General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Tucker's Pharmacy, 61 London Road, Cowplain, WATERLOOVILLE, Hampshire, PO8 8UJ

Pharmacy reference: 1031940

Type of pharmacy: Community

Date of inspection: 07/11/2019

Pharmacy context

This is a community pharmacy situated along a parade of shops on a busy main road in a residential area of Cowplain, Hampshire. The pharmacy dispenses NHS and private prescriptions. It offers a range of services such as Medicines Use Reviews (MURs), the New Medicine Service (NMS), seasonal flu vaccinations, cholesterol testing and can supply Emergency Hormonal Contraception (EHC). The pharmacy also provides multi-compartment compliance aids to people if they find it difficult to manage their medicines. And, it supplies medicines to several residential care homes.

Overall inspection outcome

✔ **Standards 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 met	1.8	Good practice	Members of the pharmacy team are trained and proactively ensure the welfare of vulnerable people in their local community
2. Staff	Standards met	2.1	Good practice	The pharmacy has enough trained staff to ensure its services are provided safely and effectively. The skill mix is suitable for the pharmacy's volume of activity, the workload is managed well and there are rotas in place to ensure the pharmacy is sufficiently staffed
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

Overall, the pharmacy has safe and effective working practices. Members of the pharmacy team monitor the safety of their services well. They routinely record their mistakes and review them to help improve the pharmacy's internal processes. Team members proactively protect the welfare of vulnerable people. And, they understand how to suitably protect people's private information. The pharmacy maintains most of its records appropriately in accordance with the law. But it does not always record enough information in its private prescription records. This means that the team may not have enough information available if problems or queries arise in the future.

Inspector's evidence

This was a busy pharmacy and in the main, well managed. Staff were observed to comfortably manage the workload. The pharmacy's dispensing activity took place in two separate areas. This included the main dispensary situated downstairs and multi-compartment compliance aids as well as medicines for the care homes were prepared from a dispensary located upstairs. The latter helped to minimise the likelihood of errors happening and reduced distractions. The layout of the main dispensary also assisted with this. At the very rear, there was a designated section for deliveries, the back portion of the dispensary was used to process repeat prescriptions and unpack deliveries, moving forward, there was a segregated area to process and assemble repeat prescriptions and the very front was used to manage prescriptions for people who were waiting. The responsible pharmacist (RP) also accuracy-checked prescriptions from a designated area here.

The pharmacy's team members had adopted several ways to manage the risks. This included using a bell on the front section. This helped alert the team that more staff were required on the front to manage the queue or to assemble prescriptions that were waiting. For the latter, one member of staff was designated to manage these prescriptions and if they started to build up, the other dispensers helped by bringing the prescriptions to the back section to process and assemble them. The workflow at the back involved one member of staff checking off and placing repeat prescriptions into a retrieval system, another processed them to generate labels whilst a third member of staff assembled them. This meant that different people were always involved in the various processes which helped to identify mistakes. The staff rota was changed daily to rotate the team between the two dispensaries and with their tasks. This helped to prevent complacency and improve the team's skill-mix. Coloured baskets were used to manage the workload and identify priority prescriptions, those requiring delivery as well as call-backs. In addition, there were baskets labelled with details of the different surgeries that prescriptions had been collected from, once the prescriptions had been processed, they were placed here. This helped reduce the time required to look for prescriptions if there were queries or if people arrived to collect them before they had been assembled.

Higher-risk medicines such as those for diabetes were stored in a separate location. Look-alike and sound-alike (LASAs) medicines were highlighted with caution notes placed in front of stock and inside drawers to visually alert the team. There were also notes placed in front of the areas where staff assembled prescriptions to help remind them about ensuring a three-way accuracy check between medicines, prescription(s) and generated labels. The pharmacy's stock holding was very organised. There were also several posters on display to highlight common LASA's such as prednisolone and propranolol as well as quetiapine and quinine. A sign-off sheet was seen to indicate that staff had read

the relevant information.

Near misses were seen routinely recorded on a log although there were gaps here with little to no details being recorded about the cause and the action subsequently taken. Staff explained that after initially documenting some details on paper, they also recorded the full details which included the root cause and remedial activity on Pharmapod (an online service). The RP and manager collectively reviewed the near misses every month to help identify trends and patterns and staff were informed. Details were seen on display about the top five contributory factors for both incidents and near misses as well as the most common types of errors being seen. The RP described looking at the timings that near misses happened. He identified if breaks were required, staff were subsequently rotated upstairs as well as with their jobs and the bell had been implemented to help prevent mistakes with prescriptions that were waiting.

Incidents were managed by the RP or the manager, a documented complaints policy was seen, and the procedure included discussing the details with the person involved, asking them about their expectations, investigating and recording details, reflecting on and rectifying the situation. A previous incident had involved the wrong strength of a medicine being supplied, this had not been taken incorrectly. In response, the RP discussed this with the team, he highlighted the difference between the two strengths and tried to ensure different brands were ordered and kept. This helped to differentiate between the two and prevent a similar mistake happening again. However, there was no information on display about the pharmacy's complaints procedure although a poster about this was seen amongst the pharmacy's paperwork. This could mean that people may not have been able to raise concerns about the pharmacy's services easily.

The pharmacy held the required standard operating procedures (SOPs) to support its services. They were reviewed in 2018. Team members roles and responsibilities were defined within the SOPs and staff had signed to confirm that they had read them. Team members understood their roles and responsibilities. Bespoke lists for the staff had also been created that highlighted the team's roles and they were on display in the dispensary. Staff knew the activities that were permissible in the absence of the RP. Further information was also on display to assist the team with the protocol. This included details contained within a table format about which activities could or could not be undertaken in the absence of the RP. The correct RP notice was on display and this provided people with details of the pharmacist in charge of operational activities on the day.

Staff had been trained to identify signs of concern to safeguard vulnerable people and provided previous examples of when this had happened. They had read the relevant SOPs, took instructions from the pharmacists and completed online training. The RP was trained to level two in 2019 via the Centre for Pharmacy Postgraduate Education and his certificate to verify this was seen. There were SOPs to support the process, the pharmacy's chaperone policy was on display in the consultation room and relevant local contact details for the safeguarding agencies were readily available.

The pharmacy informed people about how their privacy was maintained. Team members had been trained on data protection. Staff explained that after processing prescriptions, they cleared the history on the pharmacy system. If they were interrupted whilst dispensing, they stopped what they were doing and cleared the computer screen before moving away to complete that task. In addition, as there was a PC on the front counter, they kept the screen clear because people sometimes came around the counter to look at their records when the screen was used for queries. Staff usually allowed this but asked them to step back if they came into area otherwise (see Principle 3). Dispensed medicines were stored in a location where sensitive details could not be seen from the retail space and the consultation room was used if private conversations were required (see Principle 3). Confidential waste was

segregated before being shredded and staff stated that they had previously signed confidentiality statements.

Most of the pharmacy's records relating to its services were compliant with statutory requirements. This included a sample of registers seen for controlled drugs (CDs), records of emergency supplies, the RP record and records of unlicensed medicines. On randomly selecting CDs held in the cabinet, their quantities matched balances that were recorded in the corresponding registers. The maximum and minimum temperatures for the fridge were checked every day and records were maintained to verify that they remained within the required temperature range. Staff kept a complete record of CDs that had been returned by people and destroyed at the pharmacy. The pharmacy's professional indemnity insurance arrangements were through the National Pharmacy Association and due for renewal after 31 March 2020. However, records of private prescriptions had been maintained through an electronic register and there were several missing entries of prescriber details or incomplete information being recorded. This included, for example 'hospital' only as opposed to the complete name and the address of the prescriber being documented.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough staff to manage its workload safely. Pharmacy team members are suitably trained and skilled for the tasks they undertake. They have a clear understanding of their responsibilities. And, team members keep their skills and knowledge up to date by completing regular training.

Inspector's evidence

The pharmacy was well staffed by suitably skilled team members. This helped to manage the workload safely. Staff present during the inspection included the RP who was the pharmacy manager and ten trained members of staff. Four of them were working in the main dispensary, three were on the front counter and three were upstairs, one of whom was a pharmacy technician. Many team members were long-standing staff who had worked at the pharmacy for 15 years. They wore name badges, their certificates of qualifications obtained were not seen although their competence was demonstrated.

Staff described the manager being keen to rotate the team between the dispensary and counter to improve their experience in both settings, there were rota's in place to help with this and a planner on display to assist with managing annual leave. Staff were observed undertaking their tasks with very little direction required from the RP. Team members described the management team having an open-door policy and they had the confidence to raise any concerns they might have had. They also described feeding back suggestions to improve internal processes. This included creating a noticeboard upstairs which listed details about the care homes, so that staff could tick off and mark when prescriptions had been ordered, received and processed. This helped to easily and visually manage the workload. There were also several noticeboards around the main dispensary to help highlight relevant information for the team. This included one for the delivery drivers.

Team members understood their role and responsibilities, they asked appropriate questions before selling medicines over the counter, held a suitable level of knowledge to sell medicines safely and referred when required. To assist staff with their ongoing training needs, they were provided with training modules that could be completed online, they read SOPs and described completing resources from Numark. This helped to improve and keep their knowledge up to date. Staff progress was monitored annually with formal performance reviews taking place. The manager was described as providing the team with information on a one-to-one basis and staff read newsletter to keep up to date with relevant details. The pharmacist stated that there had been no formal targets set to complete services.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy's premises provide an appropriate environment to deliver its services. The pharmacy is clean, it is professional in its appearance. And, it has enough space to safely provide its services.

Inspector's evidence

On the ground floor, the premises consisted of a spacious retail space and medium-sized dispensary with segregated portions. A staff kitchenette was at the very rear, a clean staff WC to one side and a segregated space for deliveries. The pharmacy's consultation room used to provide private conversations and for services was also located at the very back, it was accessed from a passageway that ran behind the counter and down the side of the dispensary. This area contained shelving which was used for storing bags of dispensed prescriptions and sensitive details were visible to anyone entering the space to access the consultation room. People using the room during the inspection were observed to be ushered in and walked straight out without looking around or staying in this section. The room was of an adequate size for its purpose, the PC was locked after each use and there was no confidential information accessible. It was also signposted from the retail space with a poster on display to indicate that a room was available for private conversations.

The upstairs portion of the building contained vast amounts of storage space, the staff room doubled up as an office and a medium sized, care home dispensary was situated adjacent to this. Compliance aids were also assembled from the latter. Both dispensaries contained enough space to safely carry out the pharmacy's processes. Work spaces were kept clear of clutter. The pharmacy was clean and tidy. It was suitably lit and appropriately ventilated. The pharmacy's retail area was professional in its appearance although the pharmacy's fixtures and fittings were dated but still functional. Staff explained that the pharmacy was due to be refurbished soon.

Pharmacy (P) medicines were stored behind the front counter but mixed in with GSL medicines, staff were always within the vicinity and this helped restrict access by self-selection or unauthorised entry into the main dispensary. One end of this counter however, was open with no barrier in place to prevent people from coming behind it. No-one was observed walking into this area during the inspection unless they were brought in by the pharmacist for the consultation room and staff explained that if people came into this area, they asked them to step back.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy largely provides its services safely and effectively. The pharmacy team is helpful and ensures the pharmacy's services are easily accessible. The pharmacy obtains its medicines from reputable sources. It generally stores and manages them appropriately. And, the team usually takes extra care for most people prescribed higher-risk medicines. This helps ensure that people can take their medicines safely. But, the pharmacy is not always providing leaflets when medicines are supplied inside compliance aids or storing them in the most appropriate way.

Inspector's evidence

The pharmacy's opening hours were listed on the front door and some of its services were being advertised. Entry into the pharmacy was from the street via a ramp and the premises consisted of wide aisles as well as some clear, open space. This assisted people with wheelchairs or restricted mobility to easily use the pharmacy's services. Staff explained that they came around the front counter to help remove the physical barrier for people with different needs, they maintained eye contact and faced people who were partially deaf so that they could lip read or used written communication. Physical assistance was provided to people who were visually impaired, staff helped them to sign prescriptions and verbally provided details about medicines or instructions. Representatives were used for people whose first language was not English.

The pharmacy displayed some leaflets that provided information about other local services. There was documented information present that staff could use to signpost people to other local organisations. Five seats were available for people if they wanted to wait for their prescriptions and a public car park was located just behind the premises. A mobile application (Healthera) was used by people who had signed up to the pharmacy's repeat prescription and ordering system, people ordered their prescriptions through the app and details were sent direct to the surgery. Staff explained that the process had recently changed and that they were now only involved in the last part of checking and receiving the prescriptions. The pharmacy stored prescriptions for repeat dispensing in a lockable cabinet. There were individual records of supply for each person with batch prescriptions. On hand-out, staff were trained to check if there had been any changes and that people were taking their medicines as prescribed by their doctor.

The RP described proactively looking to implement services that could benefit people. He had recently implemented the cholesterol testing service to help identify people's risk of cardiovascular disease and was looking to train the team on blood glucose testing as they were keen to learn. This would also help ensure continuity with the service if he was on annual leave. In addition, the RP was in the process of completing training on travel health so that previous private services such as the supply of malaria chemoprophylaxis could be reinitiated.

The RP explained that he had removed the need for appointments for the influenza vaccination service, this was to help increase access and convenience for people. The RP was appropriately trained on vaccination techniques and resuscitation in the event of an emergency, he described another regular pharmacist being less confident initially in providing the service and to help with this, his practice had been observed by him. Suitable equipment was present such as antibacterial hand gel, wipes, a sharps bin that was normally stored inside a cabinet and adrenaline in the event of a severe reaction to the

vaccine. This helped to ensure that they provided the service safely. The service specification and Patient Group Directions (PGDs) to authorise this were readily accessible and had been signed by the RP. The RP's declaration of competence was seen. Staff ensured that risk assessments were completed, and the RP re-checked relevant details and obtained informed consent before vaccinating.

Staff were aware of risks associated with valproates, an audit had been completed in the past and was being re-initiated to identify people at risk, who had been supplied this medicine. Staff stated that they had not seen any prescriptions where intervention had been required. These medicines were stored in a separate drawer and educational material could be provided upon supply.

From the main dispensary, the team routinely identified people prescribed higher-risk medicines, relevant parameters such as blood test results were asked about and this information was obtained. The RP explained that he was in the process of completing an audit on people receiving lithium and checked whether they had received a blood test within the last three to six months, if they had received a lithium card, if they had experienced any signs of toxicity and he counselled them on the signs to be aware of as well as about their lifestyle. Details were seen recorded to verify this. Staff in the main dispensary also asked people prescribed warfarin about the International Normalised Ratio (INR) level. The RP described monitoring people's INR levels and had seen an improvement in the levels when they had started to take their medicine as prescribed. However, details were not always recorded about this. People prescribed higher risk medicines receiving compliance aids were supplied these medicines separately to the compliance aids, but staff were not routinely asking any questions or obtaining relevant details to ensure they were being taken safely. This included residents in the care homes.

Compliance aids: People were supplied with compliance aids after the GP completed an assessment to determine suitability. Once set up, staff ordered prescriptions and when received, they cross-referenced details against individual records to help identify any changes or missing items. The team checked queries with the prescriber and maintained records to verify this. Staff explained that they were also informed about changes from the GP, from people receiving the compliance aids and they received as well as retained copies of people's summaries when they had been discharged from hospital. There were also additional record sheets for each person which helped the team to keep track of when prescriptions had been ordered, received, assembled and checked as well as who these processes were carried out by. In addition, the team routinely made interventions and recorded details on the pharmacy system.

All medicines were de-blistered and removed from their outer packaging before being placed into the compliance aids. Descriptions of the medicines within the compliance aids were provided and the process for mid-cycle changes involved obtaining new prescriptions and supplying new compliance aids. However, compliance aids were sometimes left unsealed overnight, staff explained that this was because medicines required ordering, they were only left until the next working day, covered with the seal and seen stored safely to one side. There was still a risk that they could potentially be knocked, medicines moved between the compartments or contamination happening from insects or dust. The team was also not routinely supplying patient information leaflets (PILs). This meant that people may not have received all the relevant information about their medicines.

Care homes: Medicines were supplied to a few of the homes as original packs or de-blistered into compliance aids and supplied using the racking system. Either the homes ordered prescriptions for their residents and the pharmacy obtained copies of the repeat requests or staff at the pharmacy ordered them on their behalf. On receiving the prescriptions at the pharmacy, they were checked against the requests to ensure all items had been received. An audit trail about missing items was maintained and monitored by the team. As described under Principle 2, there was a whiteboard used to monitor when

prescriptions required ordering and had been ordered, when they had been processed, assembled and medication administration records (MARs) had been printed. This helped them to keep track of their workload. PILs were routinely supplied to the home. Staff described being approached to provide advice regarding covert administration of medicines to care home residents. Advice was provided after consulting appropriate reference sources and details seen documented. This included a recent intervention for someone with difficulty swallowing and the team had subsequently arranged for an alternative formulation to be supplied.

Delivery service: There were two delivery drivers who delivered dispensed prescriptions to people. There were records available to demonstrate when this had taken place and to whom medicines were supplied although they were stored in a somewhat haphazard manner. CDs and fridge items were identified, there was a separate audit trail used for delivering CDs. Signatures were obtained from people once they were in receipt of their medicines. However, there was a risk of access to confidential information from the way people's details were laid out on the records. This was discussed at the time. Failed deliveries were brought back to the pharmacy and notes were left to inform people of the attempt made to deliver their medicines. No medicines were left unattended.

During the dispensing process, staff used baskets to keep prescriptions and medicines separate. Colour co-ordinated baskets managed the workload and highlighted priority. A dispensing audit trail through a facility on generated labels helped to identify staff involvement in the various processes. Dispensed prescriptions awaiting collection were stored with prescriptions held within an alphabetical retrieval system. Details about fridge items and CDs (Schedules 2 to 4) were highlighted to help staff to identify them.

The pharmacy obtained its medicines and medical devices from licensed wholesalers such as Alliance Healthcare, AAH, Phoenix and Sangers. Quantum Specials and Movianto were used to obtain unlicensed medicines. Staff were aware of the European Falsified Medicines Directive (FMD), the pharmacy held the relevant software and equipment although it was not yet complying with the decommissioning process. Medicines were stored in the dispensary in an ordered manner. The team date-checked medicines for expiry every few months and kept records to verify that the process had taken place. Medicines approaching expiry were highlighted. There were no date-expired medicines seen or mixed batches of medicines present. CDs were stored under safe custody, the keys to the cabinet were maintained in a manner that prevented unauthorised access during the day and overnight. Drug alerts were received via email and through the company, the process involved checking for stock and taking appropriate action as necessary. There were records present to verify this. However, staff were not routinely passing this information to the care homes so that appropriate checks could be made.

Medicines returned by people for disposal were stored within designated containers prior to their collection. However, there were no separate containers to store hazardous and cytotoxic medicines although there was a list available for staff to identify these medicines. People returning sharps for disposal were referred to the local council for collection and provided with relevant contact details. Details were taken about returned CDs and they were brought to the attention of the RP before being appropriately stored and destroyed.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the necessary equipment and facilities it needs to provide its services safely. The pharmacy keeps its equipment clean and uses its facilities appropriately to protect people's privacy.

Inspector's evidence

The pharmacy was equipped with current versions of reference sources and clean equipment. This included standardised conical measure for liquid medicines, designated ones for methadone, counting triangles and the dispensary sink that was used to reconstitute medicines. The latter did require de-scaling from the lime scale that had accumulated. There was hot and cold running water with hand wash available. The fridges used for medicines requiring cold storage were operating at appropriate temperatures. The CD cabinets were secured in line with legal requirements. The blood pressure machine was calibrated annually, the cholesterol monitoring meter was new, and the pharmacist had been keeping calibration records. Computer terminals were password protected and positioned in a manner that prevented unauthorised access. Staff held their own NHS smart cards to access electronic prescriptions and they were taken home overnight. A shredder was available to dispose of confidential waste.

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.