General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Stone Pharmacy, 86 Booth Ferry Road, GOOLE, North Humberside, DN14 6AA

Pharmacy reference: 1032032

Type of pharmacy: Community

Date of inspection: 24/07/2019

Pharmacy context

The pharmacy is in Goole, North Humberside. It dispenses NHS and private prescriptions and sells over-the-counter medicines. The pharmacy offers a prescription collection service from local GP surgeries. And it 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 a substance misuse service.

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 generally manages risks to its services. And it records mistakes that happen whilst dispensing. The pharmacy mostly keeps the records it needs to by law and keeps people's private information safe. The pharmacy team members know how to protect the safety of vulnerable people. The pharmacy has some procedures for pharmacy team members to follow. But these are not reviewed in a timely manner.

Inspector's evidence

There was a generously sized retail area to the front. And a smaller pharmacy to the rear. The pharmacy had a set of SOPs which were out of date. They were last reviewed in March 2015. They were signed and authorised by the previous SI before the pharmacy changed hands. Some staff had signed these. The manager had not. The new SI was in the process of updating these.

The pharmacy had a paper log to record near miss incidents. The pharmacist usually recorded these. And handed the error back to the dispenser responsible to correct. There had been eight near misses recorded in May and six in June. None had been recorded in July to date. The records lacked some details such as the contributory factors. And the learning point on all of those completed was to ‘read script carefully’. The monthly patient safety review (MPSR) had last been completed in January 2019. The key learning points were to read prescription carefully. And to separate the look alike sound alike (LASA) drugs. Some of these were separated on the shelf. Dispensing errors were recorded on the community pharmacy medication safety incident report form. An error was reported in April 2019. The wrong strength of Bisoprolol had been supplied to a person. The pharmacist had discussed the error with the pharmacy team members. There were no notes or records of these conversations.

The pharmacy team members were unsure if there was a procedure for handling complaints. But they advised that they refer to the pharmacist when a customer is unhappy with the service they have received. There was no pharmacy leaflet in the pharmacy. And this may mean the people who wanted to complain cannot access all the information they need. Some customers were unhappy with the number of out of stock items. The manager said that they always ring round all of their suppliers and try different wholesalers.

The pharmacy had appropriate professional indemnity insurance. A sample of the CD register entries checked met legal requirements. The pharmacy maintained the register with running balances. And these were audited irregular. The private prescription records looked at were complete in most cases. The reason for the emergency supply was not always noted in the book. A register was maintained of CDs returned by patients for destruction indicated that there were a lot of patient returned CDs that had not been destroyed in a timely manner. A sample of records for the receipt and supply of unlicensed products looked at found that the invoices were not kept with the certificates of conformity. And patient details were included.

Pharmacy staff had completed information governance training. But this had been some years ago. The medicines counter assistant had recently completed data protection training as part of her course. Confidential waste was segregated. And this was shredded on site. The team were aware of the importance of the need to protect people's private information. The pharmacy's team members were

aware of safeguarding issues. The contact details for local safeguarding organisations were available. A team member said that they would escalate incidents to the manager initially.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough suitably trained and skilled team members to provide its services safely. The pharmacy team members receive some adhoc training to keep their knowledge up to date. They discuss tasks and workload to make sure they provide pharmacy services in a timely manner.

Inspector's evidence

The pharmacy team, on the day consisted of the RP who was the manager. A technician and two trainee counter assistants. There was a dispenser on holiday. The rest of the pharmacy team members took on his usual tasks. There was an extra counter assistant who was helping cover his hours. The manager advised that a new member of staff had been employed to work between the two company pharmacies in the area. Members of the pharmacy team had completed healthy living pharmacy (HLP) training. And one member of the team had completed risk management training. The pharmacy team read information that was provided through manufacturers about new over the counter medicines. The manager had chats with the pharmacy team members about medicine sales for medicines such as chloramphenicol and hydrocortisone cream.

The pharmacy team had discussions about tasks that needed completing. And about dispensing incidents. There were no notes taken at these discussions. Performance reviews were not being done. But that was something the new management team were discussing. Targets were in place MURs. And the manager felt some pressure to complete these.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy’s premises are clean, secure and suitable to provide its services safely. The pharmacy’s team appropriately manages the available space. And it has a suitable consultation room for people to have private conversations.

Inspector's evidence

The pharmacy had the front window shutters down. And the pharmacy looked closed. The manager said that there was a fault with the mechanism. And this had been reported to the area manager. The pharmacy premises were cluttered in places but were basically clean. The dispensary had separate areas for dispensing and checking prescriptions. There was a door into the consultation room from the dispensary. And another from the retail area. The consultation room did not lock. But there was no confidential information stored there. And it was suitable for private consultations and counselling. There was a desk, chairs and a sink. Its location was well advertised. The layout of the premises was such that confidential information was not visible from the public areas. The pharmacy’s premises were appropriately safeguarded from unauthorised access. There was adequate heating and lighting throughout the premises. And running hot and cold water was available.

Principle 4 - Services ✔ Standards met

Summary findings

People with a range of needs can access the pharmacy's services. The services are generally well managed. The pharmacy gets its medicines from reputable suppliers. And it mostly stores and manages its medicines appropriately. The pharmacy manages the risks when it dispenses medicines for people into multi-compartmental compliance packs. And it provides these people with information to make sure they can identify their medicines. It supports people taking high-risk medicines. But the pharmacy's processes are not all robust, so the team may miss opportunities to give these people extra advice.

Inspector's evidence

There was access from the street into the pharmacy. There were some leaflets on display for self-selection. Multi-compartmental compliance packs were supplied to people to help them to take their medicines on time. The trays included tablet descriptions. So that people could identify each medicine. Patient information leaflets (PILs) were supplied monthly. The pharmacy offered a free delivery service to people in their own homes. The delivery driver got signatures from the person accepting medicines. Controlled drugs cabinets were available for the safe custody of controlled drugs. The cabinets were appropriately secured. There were a lot of patient returned CDs. And some out of date CDs in the controlled drugs cabinets. Dispensed controlled drug or fridge items such as insulin were stored in clear plastic bags which provided the opportunity for additional accuracy checks when being collected by the patient.

The pharmacy shelves were overcrowded. And this meant that some medicines were not adequately segregated. For example, methotrexate was mixed with lisinopril and melatonin. This increased the risk of a picking error. The technician opportunistically highlighted short dated items. There were no out of date medicines on the section sampled. Liquid medication was marked with the date of opening. This meant that checks could be done to make sure the product was safe to supply. For example, Peptac liquid was marked as opened on 7 June 2019. Coloured baskets were used to ensure prescriptions were prioritised and assembled medication remained organised. Computer generated labels included relevant warnings and were initialled by the pharmacist and dispenser which allowed an audit trail to be produced. There was an adequately sized retrieval area where dispensed medication for collection was stored.

The manager was aware of the valproate Pregnancy Prevention Programme. And was aware that there was guidance that had to be provided to people who may become pregnant who received valproate. The leaflets were not on the shelf near to the stock. And were not located in the pharmacy. This may mean that opportunities are missed to advise people about the safe use of their medicines. The manager said that there were two female patients receiving valproate. But neither were eligible under PPP. There was no system in place to alert the pharmacist when high risk medication such as warfarin was handed out. This may mean that opportunities are missed to advise people about the safe use of their medicines.

Out of date stock and patient returned medication were disposed of in pharmaceutical waste bags for

destruction. These were stored securely and away from other medication. A sample of invoices showed that medicines and medical devices were obtained via licensed wholesalers. Stock requiring refrigeration was stored at appropriate temperatures. And electronic records were maintained to ensure temperatures were within the appropriate ranges. The records showed that these were consistently recorded. The pharmacy team members said that the pharmacy had not yet adjusted to meet the Falsified Medicines Directive (FMD). The scanners were in place. But the pharmacy team members had not received training. So, the pharmacy wasn't compliant with FMD requirements. Recalls and MHRA alerts were received electronically. These were printed off and actioned. And then discarded. So, there was no assurance that all the alerts had been received and actioned.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the necessary equipment needed to provide the pharmacy services it offers. It is stored appropriately and used in a way that protects the privacy and dignity of people.

Inspector's evidence

Up-to-date reference sources were available and included the British National Formulary (BNF) and BNF for Children. There was access to the internet which was used for a range of uses including leaflets for patients and there was access to PharmOutcomes. A range of CE quality marked measures were in use which were cleaned after use. The pharmacy also had a range of equipment for counting loose tablets and capsules with a separately marked tablet triangle that was used for cytotoxic drugs. Tweezers and gloves were available. There was a first aid kit.

The CDs were stored in CD cabinets which were securely bolted in place. The fridge used to store medicines was from a recognised supplier and an appropriate size for the volume of medicines requiring storage at such temperatures.

The pharmacy computer terminals and PMR were password protected. The computer screens were out of view of the public. Access to patients' records restricted by NHS smart cards. Medication awaiting collection was stored out of view and no confidential details could be observed by customers. Prescriptions were filed in boxes out of view of patients keeping details private.

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.