General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Johnston Pharmacy, 50-52 Johnston Street, BLACKBURN, Lancashire, BB2 1HD

Pharmacy reference: 1033099

Type of pharmacy: Community

Date of inspection: 11/06/2019

Pharmacy context

This is a community pharmacy in a residential street, close to a few other shops on the outskirts of town. It dispenses NHS and private prescriptions and sells over the counter medicines. The pharmacy provides a substance misuse service, including supervised consumption and needle exchange. It supplies medicines in multi-compartmental compliance packs for people living at home. And it delivers medicines to people's homes.

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 met	N/A	N/A	N/A
2. Staff	Standards not all met	2.2	Standard not met	The pharmacy hasn’t enrolled a new member of the team on a GPhC accredited training course as required. And the team member hasn't read the standard operating procedures appropriate to her role.
3. Premises	Standards met	N/A	N/A	N/A
4. Services, including medicines management	Standards not all met	4.2	Standard not met	The pharmacy doesn't have appropriate safeguards in place for all its services. It doesn't have a robust process for medicines it delivers to people’s homes. The pharmacy doesn't keep a record of the deliveries it completes each day. And it doesn't obtain signatures from people it delivers to, except for controlled drugs. So, there was no audit trail for any part of the service.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance ✔ Standards met

Summary findings

The pharmacy mostly identifies the risks associated with its services. And it has written procedures to help the team manage the risks. But not all team members have read the procedures as part of their training. So, they may not all follow the agreed way of working. The pharmacy team members understand the importance of recording and learning from mistakes that happen during dispensing. But they don't keep up to date records. So, it is difficult for them to understand what changes to make to improve the safety and quality of pharmacy services. The team members know how to protect the welfare of children and vulnerable adults. The pharmacy keeps most of the records of must by law. It takes some steps to ask for people's feedback. And it keeps people's private information safe.

Inspector's evidence

The pharmacy was undergoing a refit and some of the works were visible to people accessing the pharmacy. The premises comprised of a shop area and a pharmacy counter. And there was a consultation room off the shop floor, but this was part of the refit and not available for people to use at the time of the inspection. The dispensary area was set off to one side of the pharmacy counter. And there was a hatch from the shop into the dispensary area, so people could speak directly with the pharmacist and this was where people mainly accessed the substance misuse service. One of the dispensing benches was directly under the hatch area. But the pharmacy team recognised the risk to people's confidentiality and didn't leave any private information on that bench.
The pharmacy had a set of standard operating procedures (SOPs) for the services it provided. There included SOPs for dispensing, date checking, and pharmacy services provided. They had been written in 2017 and were due for review in September 2019. There was no SOP relating to delivery of medicines available to be seen during the inspection. The team were sure there had been a SOP detailing the delivery process. The team members had signed the training sheets that were stored at the back of each SOP. But the new member of the team hadn't signed the training records to confirm she had read the SOPs. She had thought she had read some procedures when she started but she couldn't be sure what they were.

The pharmacy kept a near miss and dispensing incident record book on the shelf in the dispensary. It took some time to find the book. And the last entry had been in 2018. The pharmacist said the level of near misses seen were low, and this was reiterated by the team. But they did admit that near miss recording had slipped. The technician spoke about how she would separate medicines that looked alike to reduce the risk of a selection error. But she couldn't think of any recent examples. There were no alert stickers seen on the dispensary shelves. Analysis of trends had not been completed recently. But the team members said they would discuss any potential risks and near misses at the time to reduce the risk of further errors. The team members recorded dispensing incidents in the same book. They couldn't remember the last time there had been a dispensing incident. No records were seen. There was a discussion about how to encourage recording of errors and the importance of learning and potentially making changes when errors occurred.

The SOPs detailed the roles and responsibilities for tasks. The correct Responsible Pharmacist notice was on display during the inspection. The pharmacy technician was seen referring a child who potentially had chicken pox to the pharmacist for advice. The trainee MCA/dispenser had a general idea what services couldn't be provided when there wasn't a pharmacist on the premises. She would never

give out completed prescriptions or sell products without referring to the pharmacist or another member of the team.

The pharmacy kept the responsible pharmacist (RP) records electronically. For the sample checked, 1st – 31st May 2019, the records met the requirements. There had been no absences recorded during this time. Of the sample checked the paper private prescriptions records were complete and accurate. Emergency supply records were kept on the computer, and of the small sample seen there was a section to complete detailing the reason for the emergency supply. But on the records checked the reason wasn't visible. The pharmacy didn't dispense many unlicensed medicines, "specials." The pharmacist explained how he completed the certificates of conformity. But the records couldn't be found during the inspection. The pharmacy kept electronic controlled drug records. And it printed out copies monthly. A sample of the entries in the CD register met legal requirements. The system maintained running balances from the entries made. And the team completed weekly checks of the physical stock balance of CDs against the register entry. The details of the checks were as a recorded as an entry in the electronic CD register. During the inspection a check of the physical balance of methadone 1mg/1ml liquid was checked against the register balance. An overage was found. On investigation there had been an incorrect entry made, so after the amendment the overage was found to be within acceptable limits.

The pharmacy had up to date indemnity insurance.

The pharmacy had a poster on display near the counter detailing how people could provide feedback and raise concerns. The pharmacy had previously asked for people's feedback via an annual questionnaire. And it advertised the results of this survey on NHS.co.uk and in the dispensary. But it hadn't completed or submitted the latest survey results due to the low number of people responding. This was thought to be due to low footfall into the shop. The pharmacist had read some of the responses and he said these had been positive. The team members couldn't think of any recent complaints but said they would escalate any concerns to the pharmacist.

The pharmacy had submitted the NHS information governance toolkit in 2019. The team members could clearly explain the steps they took to protect people's private information. But they hadn't received any formal training on the General Data Protection Regulation (GDPR). They could describe changes they had made to improve confidentiality in the workplace. The pharmacy didn't display a privacy notice. And it didn't tell people the types of data the pharmacy held and how it was used. It held confidential waste separately from general waste in white sealed sacks. There were a number of sacks awaiting collection in the rear room.

The pharmacist and pharmacy technician had completed the CPPE Level 2 safeguarding course in 2017. But the pharmacy team, including the new trainee hadn't received any formal training on how to recognise concerns. The pharmacy had a poster in the dispensary detailing the local safeguarding contact details. The team members said they would refer any concerns to the pharmacist.

Principle 2 - Staffing Standards not all met

Summary findings

The pharmacy has enough staff to provide its services and most of the team have the skills and knowledge for their roles. But the pharmacy hasn't enrolled a new member of the team on a GPhC accredited training course as required. And the team members don't have a formal induction or training plan. So, it may be difficult for new members of the team to acquire the skills and knowledge they need to complete tasks. The pharmacy team members feel comfortable to feedback their ideas and raise concerns if necessary.

Inspector's evidence

During the inspection the pharmacy had three work experience students cleaning and tidying stock in the shop. They were only working for one week and they didn't complete any dispensing activities or provide any advice to people accessing pharmacy services. They hadn't read the SOPs and didn't have a workbook from the college to identify their learning aims for the work experience. Also present during the inspection was the Responsible Pharmacist, who was the superintendent of the family owned business. And one trainee medicine counter assistant (MCA)/dispenser, one part time pharmacy technician and one full time NVQ 2 qualified dispenser (certificate seen). A part time dispenser and a driver also worked in the pharmacy, but they weren't present during the inspection. The trainee MCA/dispenser had worked in the pharmacy since the end of 2018 / Jan 2019, but the pharmacy had not enrolled her on a GPhC accredited course. And she hadn't signed the training record to indicate she had read the SOPs. She had limited knowledge of pharmacy. She served and put stock away. And she didn't give advice to people. She referred all queries to another member of staff or the pharmacist.

The team was seen managing the workload during the inspection in an organised way. The pharmacy technician was seen directing the work experience students and the new member of the team.

The pharmacy team members didn't have a regular training plan. The pharmacy technician kept her knowledge up to date as part of her revalidation. She had completed safeguarding training and substance misuse training in 2017. And more recently she described completing an oral health module. She completed her training at home and she said she could concentrate better this way. The dispenser said he kept up to date learning directly from the pharmacist and technician. He was considering starting the NVQ 3 technician course. He recalled how he had recently learnt about the changes in the CD schedule of gabapentin. The new member of the team hadn't completed any formal training. They read articles in training magazines and browsed the internet to learn. The pharmacy team members didn't have formal appraisals. They said they felt comfortable raising concerns or providing feedback about ways of working directly with the pharmacist during the working day. The technician said she felt her concerns would be listened to and if she had to escalate a serious concern she knew how to do this.

The pharmacy didn't set any targets for services provided. The pharmacist said he tried to set personal objectives for services provided.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is secure and generally maintained to the required standards. But the pharmacy is completing improvement works, to improve the space available. But it hasn't a clear plan when this will be completed. And the work has already continued for a substantial amount of time. So, the pharmacy doesn't portray a professional environment. And it doesn't have a usable room, so people can have private conversations with the team.

Inspector's evidence

The pharmacy had a glass front with some posters in the window. The facia looked like it had recently been changed and was painted black, but there was no signage to indicate it was a pharmacy. There was nothing in the window either to indicate it was a pharmacy. It didn't advertise any of its services or its opening times. The pharmacist said this work had been ongoing since 2017 and it involved all areas of the pharmacy. The refit had been ongoing at the last GPhC inspection. It was apparent for people using the pharmacy that building and improvement work was being done. In areas of the shop there were electrical wires on show that could potentially be a trip hazard. And the ceiling at the front of the shop was sealed with a number of wooden boards. Although these didn't seem to be causing an immediate health and safety risk it didn't portray a safe or professional environment for healthcare. The pharmacist said they had a barrier to cordon off areas in the shop. But this was not in place during the inspection.

The room to the rear of the current dispensary was a work area. It had been gutted and the walls and floor redone and sealed. The team had a toilet and handwashing facilities with hot and cold running water. But the team had to go through the work area to access the facilities. And it was the only sink facilities in the pharmacy. So, the team had to use this sink as part of medicines preparation. It had tried to mitigate some of the risks by transferring the water back to the dispensary to reconstitute medicines etc. A discussion was had during the inspection about the importance of rectifying this promptly during the refit. The pharmacy planned a second sink in this rear room, which was to be used for dispensing purposes. The pharmacy had limited bench space in the current dispensary and some dispensing baskets were stacked on top of one another awaiting checking. It had limited storage space for stock. The staff didn't have a kitchen area. These would be rectified with the completion of the refit.

The consultation room was part of the refit and not in use at the time of the inspection. Part of the ceiling had been removed, so its wasn't soundproofed. And it was being used as a stock room, whilst work was done elsewhere in the premises. The plan was to finish the back room by end of summer. It was discussed during the inspection the importance of having a plan to complete the refit, with dates. The pharmacy didn't portray a professional image. And although understandable for a short time period during a refit this was not acceptable for a longer period of time. The pharmacy needed a plan to complete the improvement works.

The pharmacy used local contractors for any maintenance issues. The pharmacy had 2 heaters and the temperature was adequate on the day of the inspection. The lighting was adequate.

Principle 4 - Services Standards not all met

Summary findings

The pharmacy has appropriate processes in place for some of the services it provides. But it doesn't have a robust process or audit trail for medicines it delivers to people's homes. So, it will be difficult to investigate and resolve if there are any queries or mistakes. The pharmacy identifies people on high-risk medicines and takes extra care to monitor their treatment. But it doesn't always have the written information to give to people to help them take their medicines safely. The pharmacy sources its medicines from licenced suppliers. And it generally stores and manages its medicines appropriately.

Inspector's evidence

The pharmacy had a poster near to the counter advertising the pharmacy's services. The pharmacy had posters advertising its needle exchange service close to the hatch into the dispensary. And a notice alerting people to the importance of safe storage of methadone. The pharmacy didn't have a practice leaflet on display, detailing its opening hours or services. So, people didn't have any written information they could take away.

The pharmacy's consultation room wasn't fit for purpose due to the refit. And this limited the services provided in the pharmacy. The pharmacist explained how he would signpost people for services he couldn't provide. He said he had completed the occasional MUR at the weekend in the dispensary area when he was able to talk confidentially.

The pharmacy team used baskets during dispensing to keep people's prescriptions and medication together. And it also helped to prevent people's prescriptions from getting mixed up. The team signed the dispensed by and checked by boxes on most of the dispensing labels to provide an audit trail of the dispensing process. And to take responsibility for their work. The pharmacy used stickers for fridge lines and CDs. The pharmacy gave people an owing slip when it couldn't supply all their medicines first time. The prescription was used throughout the dispensing process until the full quantity had been supplied.

The pharmacy supplied medicines in multi-compartmental compliance packs for approximately 50 people living in the community. The team had some packs awaiting checking during the inspection. The packs were stored in a basket, with the prescriptions, the original packaging and the patient information leaflets. The dispenser had added the descriptions of the medicines to the pack next to the dispensing labels, so people could identify the medicines in the pack. But the pharmacy didn't have a dispensing audit trail as the dispenser hadn't completed the dispensed by box on the pack. The full time dispenser managed the service. And all the dispensing team supported with dispensing. The dispenser ordered people's prescriptions in advance, so any queries could be resolved. The team assembled the medication to make sure all items were in stock before dispensing the pack. And the pack was checked by the pharmacist as soon as possible. The pharmacy had limited bench space, so this prevented part-assembled packs taking up space on the bench. If the pack required many different tablets adding or the tablets were of the same colour, the pharmacist watched the dispenser assemble the pack. This was to reduce the risk of errors not being identified during the accuracy check. The pharmacy didn't use master record cards detailing the times of administration and other useful information about people's medication. But the dispenser did say this was planned to start. The pharmacy relied on the specific dosage times being added to the dispensing label.

The pharmacy provided a home delivery service for a large percentage of the prescriptions dispensed. It completed 30 – 50 deliveries a day. The pharmacy couldn't evidence a delivery SOP, although the team did state the pharmacy had one. For the deliveries of CDs, the pharmacy used a form to capture people's signatures. Previously the driver had obtained signatures for all deliveries, but as the service volume had increased this had been more difficult to complete and so had been stopped. The team annotated the PMR with the wording "collect" for people who came into the pharmacy to collect their medication. And all other prescriptions were delivered. The pharmacy didn't evidence any consent for this service. The pharmacy didn't keep a list of the deliveries it completed each day. So, there was no audit trail for any part of the service.

The team dispensed methadone for people and provided a supervised consumption service. The pharmacist dispensed the methadone in the morning, so people's medicines were ready when they accessed the pharmacy. But he didn't get a double check. The dispensed by and checked by signature boxes were not all completed. This was discussed during the inspection. As part of the process the initials of the patient were highlighted in large print on the outer packaging or bottle lid. And the team stored the medicines appropriately in the CD cabinet, separated in a basket form other stock. These actions helped to reduce the risk of errors.

The team was aware of the clinical issues regarding valproate and pregnancy and did have a prevent leaflet. But the team seemed unsure of the details of the valproate pregnancy protection programme. The pharmacy didn't have any written material to give to people. And as most people had their medicines delivered it may be difficult to give them advice. The team said they didn't have anyone on valproate regularly, but they would contact the company to get a VPPP pack. The pharmacist made checks on people's INR if they were taking warfarin. And he liaised with the doctor to get prescriptions issued.

The pharmacy used a number of licenced wholesalers to obtain its medicines for example DE for methadone liquid.

The pharmacy stored its prescription only (POM) stock on shelves in the dispensary. And it stored pharmacy (P) medicines behind the counter to avoid self-selection. But the P medicines and POMs were next to each other on the shelves without adequate segregation, due to space issues during the refit. So, there was a potential for confusion particularly for unqualified team members and people accessing the pharmacy.

The pharmacy had a date checking SOP for the team to follow. The team members said they completed regular date checks. There was evidence of short dated stickers on stock on the shelves. No out of date medicines were found in the sample checked. The team had a book to refer to at the start of each month to remove the short dated stock before it expired. But it didn't keep a record of which parts of the dispensary and shop had been completed and when. So, the pharmacy didn't have a robust audit trail to refer to.

The pharmacy kept fridge temperature records electronically, the system sent an alert to the team to remind them to record it daily. The team could only access the last 7 days of records, which may mean it could be difficult to spot a gradual decline in effectiveness. The temperature had been in range for the previous 7 days. The temperature was 4.6 degrees Celsius during the inspection. The CD cabinet was an appropriate size and well organised. The pharmacy team separated stock from medicines awaiting collection. And it kept patient returned and out-of-date CDs separate. The pharmacy had CD denaturing kits available to destroy CDs.

The pharmacy had scanners to meet the requirements of the falsified medicines directive (FMD). The team understood the requirements of FMD but were not verifying or decommissioning as part of the dispensing process. The SOPs had not been updated.

The pharmacy team received email notification of safety alerts and drug recalls from the Medicines and Healthcare products Regulatory Agency (MHRA). The team kept an electronic record of the emails but didn’t record what action had been taken. The team said they used to do this. The pharmacy had a SOP relating to safety alerts for the team to follow.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide its services. But it doesn't always keep a record of when some equipment was last tested. So, it can't evidence how accurate it is.

Inspector's evidence

The pharmacy had hard copies of reference books available for the team to use, including the BNF, the BNF for children and Stockley's interactions book. And the team had access to the internet. The pharmacist accessed the internet during the inspection to obtain up to date information about an eye drop before giving advice. The pharmacy had a domestic fridge, rather than a medical fridge, and it was in working order. There was evidence of electrical safety testing, with stickers attached to plugs. The pharmacy offered a free blood pressure checking service. And it had a CE marked Omron blood pressure machine. But the team didn't know when it had been calibrated or how old it was. So, it was difficult to know if the readings were accurate. The pharmacy had a range of glass crown stamped measures, with separate ones to measure methadone liquid.
The computers were password protected. The pharmacy positioned the computers in the dispensary in a way to prevent disclosure of people's private information. The screens couldn't be seen by people waiting at the counter or the hatch. The pharmacy team stored assembled bags of medicines so confidential information couldn't be seen by people in the shop.

The responsible pharmacist had an NHS smart card, but it wasn't his card in the PMR at the start of the inspection. It was his father's smart card. The RP changed it when the matter was brought to his attention by the inspector.

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.