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: 16/01/2020

Pharmacy context

This is a community pharmacy in a residential street, close to a few other shops on the outskirts of town. It mainly dispenses NHS prescriptions and sells over-the-counter medicines. The pharmacy provides a substance misuse service, including supervised consumption and needle exchange. It supplies some medicines in multi-compartment compliance packs for people living at home. It has a home delivery 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	1.2	Good practice	The pharmacy regularly records its near miss errors. And these records detail the learning and action taken to help prevent similar errors. The pharmacist reviews these records monthly to identify any trends. And he discusses his findings with the team members.
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 identifies and manages the risks associated with its services. And it has up-to-date written procedures to help the team work safely and effectively. The pharmacy team members are good at recording and discussing learning from mistakes that happen during dispensing. And they take appropriate action to minimise the risks of similar mistakes. Team members keep people's private information safe. And they mostly keep the records they must by law. They know how to help protect the welfare of children and vulnerable adults.

Inspector's evidence

The pharmacy had an up-to-date set of standard operating procedures (SOPs) for the services it provided. It had an index, so it was easy to refer to a particular SOP. The SOPs included ones for dispensing, delivery of medicines, controlled drug (CD) management, Responsible Pharmacist (RP) regulations and other pharmacy services it provided. These had been updated in September 2019, following the previous inspection. All team members had read the SOPs and completed the training record sheets. The SOPs were due for review in September 2021. The RP SOP had a matrix template, detailing tasks that could be completed by different staff roles. But this had not been completed for the team members in the pharmacy. The correct Responsible Pharmacist notice was on display during the inspection. The team members were seen working within the scope of their roles and offering appropriate advice. They referred people's queries to the pharmacist when necessary. The trainee dispenser confirmed she referred queries that she couldn't answer to the pharmacist.

The pharmacy used a near miss error record book. The pharmacy team had regularly completed records of near miss errors since the last inspection. And full details of actions taken were recorded. A recent error highlighted the similar packaging of Daktarin and Daktacort. And the action taken was recorded as having separated the two products. The two products were seen clearly separated on the dispensary shelves. The team described how they had discussed the error together and agreed to separate the two products. Other actions following near miss errors, included discussing the error with the team members to share learning and tidying the shelves to prevent selection errors. The pharmacy team regularly discussed any near miss error misses made. The pharmacist analysed these and completed a monthly patient safety review. He shared the details with the team. The pharmacy had a separate form to complete for any dispensing incidents. The pharmacist explained there had been no dispensing incidents since the introduction of these forms, so there were no completed forms to view. The team members were aware of the risks with dispensing medicines that look-alike and sound-alike (LASA) and they had recently completed some training to help reduce these errors.

The pharmacy displayed a poster near the counter detailing how people could provide feedback and raise concerns. And it had this information in its practice leaflet. 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, but these were from 2017. During the inspection there were questionnaires on display on the pharmacy counter for people to complete. The team members couldn't think of any recent complaints but said they would escalate any concerns to the pharmacist.

The pharmacy displayed an out-of-date certificate for professional indemnity insurance. But the pharmacist had an email from the NPA confirming the pharmacy had up-to-date cover. The pharmacy

kept the responsible pharmacist (RP) records electronically. For the sample checked, the records met requirements. The pharmacy had paper private prescriptions records that were mostly complete and accurate. Some entries didn't have the prescriber's address entered into the record. Emergency supply records were kept electronically and of the small sample seen this included the reason for the emergency supply. The pharmacy kept records of unlicensed medicines purchased. The certificates of conformity were mostly complete but were missing the prescriber's details. The pharmacy kept electronic controlled drug records. 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 checks of the physical stock balance of CDs against the register entry, mostly once a month. 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 balances of methadone 5mg tablets and Durogesic 12 microgram patches were checked against the register balances. These were found to be correct.

The pharmacist had submitted the Data Security and Protection toolkit in 2019. The team members knew the importance of keeping people's private information secure. A team member described how she would take private telephone conversations in the back room so people in the retail area couldn't overhear these conversations. The team members hadn't received any formal training on the General Data Protection Regulation (GDPR). And they couldn't find the pharmacy's information governance policy or procedure. The pharmacy displayed a privacy notice and informed people about the NHS code of practice on confidentiality in its practice leaflet. It held confidential waste separately from general waste in white sealed sacks. There were a small number of sacks awaiting collection stored neatly in the rear room.

The pharmacist and pharmacy technician had completed the CPPE Level 2 safeguarding course in 2019. The pharmacy had a SOP relating to safeguarding and all team members had read and completed the training record to confirm understanding. The pharmacy displayed local safeguarding contact details. The team members described how they would refer any concerns to the pharmacist.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has a team with the qualifications and skills to provide its services. It supports team members to complete ongoing training relevant to their roles and to the services provided. The team members work well together to complete the workload. And they support newer members of the team to learn and to complete their tasks. The pharmacy team members feel comfortable to feedback their ideas and raise concerns if necessary.

Inspector's evidence

During the inspection the RP was the superintendent of the family owned business. He worked most day's when the pharmacy was open. And there was regular pharmacist cover when he was absent. He had one trainee dispenser, one part-time pharmacy technician and one full-time NVQ 2 qualified dispenser supporting him. Another part-time dispenser and a driver also worked in the pharmacy but weren't present during the inspection. The previous inspection, six months earlier, identified that the newest member of the team hadn't been enrolled on a GPhC accredited training course. And she hadn't read any of the pharmacy's SOPs. She was now enrolled on an NVQ level 2 dispenser's course and was working her way through it. She felt supported by the superintendent and other members of the team to complete her course and to learn. During the inspection she was being closely supervised and supported by the pharmacy technician whilst she dispensed medicines into multi-compartment compliance packs. She had signed the training records to confirm that she had read the updated SOPs. She had a training record, indicating the modules completed and the percentage completion of her course.

The team was seen managing the workload during the inspection in an organised way. The refit meant that there was additional bench space in the back room. The workflow was better organised as the team members dispensed medicines into the compliance packs on this bench. The pharmacists and pharmacy team members completed ongoing learning, and this was recorded in a training record file. The training was appropriate for the team members roles and for the services provided. Training had been completed regularly over the past few months included training relating to LASA medicines, risk management, substance misuse, safeguarding and treatment of thrush. The pharmacy didn't forward plan its training but completed training associated with the NHS contract as this was felt to be relevant. Team members described how they felt comfortable raising concerns and providing feedback about ways of working directly with the superintendent. They felt their concerns would be listened to. The technician knew how to escalate a serious concern if necessary. The pharmacist set his own personal objectives for the provision of services to make sure he provided services to benefit people.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy's premises are secure and maintained to the required standards. The pharmacy has completed improvement works to improve the space available to deliver its services. And it portrays a professional image.

Inspector's evidence

The premises were much improved since the last inspection six months previously. The pharmacy's name was clearly indicated on the facia outside. It had a window ladder displaying the pharmacy's services in the window. And the opening hours were clearly displayed there too. The refit was almost complete. There was a new ceiling with appropriate lighting. The pharmacy used local contractors for maintenance issues. The pharmacy had heaters and the temperature was adequate on the day of the inspection. The temperature was warm around the heaters but colder in the consultation room.

The refit had been completed in the dispensary area, including the room to the rear of the current dispensary. The pharmacy had additional bench space, a staff area for making drinks and a second sink with hot and cold running water. This was used for medicines preparation. The team had new toilet and handwashing facilities, with hot and cold running water. The pharmacy team had a cleaning rota. And the pharmacy was clean and tidy, with no slip or trip hazards.

The consultation room had not been fit for purpose on the last inspection. It had been updated as part of the refit and was close to being complete. It was soundproofed and the renovations were complete. But people couldn't sit down with the pharmacist. There were work ladders stored in there. It was clear of all stock. But one side of the room had a full-length outside glass window, so people on the pavement outside could see directly into the room. The superintendent had plans to rectify this imminently.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy advertises its services and makes them easily accessible to people. It has suitable procedures to help the team manage and deliver its services safely and effectively. It delivers medicines to people at home. And team members use technology to track deliveries. And they obtain signatures from people for the receipt of their medicines. So, they can easily respond to any queries. The pharmacy identifies people on higher-risk medicines and takes extra care to monitor their treatment. The pharmacy sources its medicines from licenced suppliers. And it stores and manages its medicines appropriately.

Inspector's evidence

The pharmacy was accessible to people from the pavement outside, including people using wheelchairs and with prams. It advertised its services using posters, a window ladder and in its practice leaflet. 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 team used baskets during dispensing to keep people's prescriptions and medication together. And to help prevent people's prescriptions from getting mixed up. The team signed the dispensed by and checked by boxes on 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. Some team members had recently completed training relating to the NPSA safety alert regarding valproate in pregnancy. The pharmacy had a SOP detailing the requirements to be followed when supplying valproate. The team members had signed the training record sheet to indicate they had read the SOP. They were aware of the clinical issues regarding taking valproate during pregnancy and had written material in the training pack. But they couldn't locate further supplies of the cards, stickers and guides during the inspection. The technician demonstrated the valproate audit that they were completing. The pharmacist made checks of people's INR if they were taking warfarin. And he liaised with the doctor to get prescriptions issued.

The pharmacy supplied medicines in multi-compartment compliance packs for some people living in the community. The team members dispensed the packs in the newly fitted room at the rear of the main dispensary to avoid distractions. They had some packs awaiting checking during the inspection. The team members stored the packs in a basket, with the prescriptions, the original packaging and the patient information leaflets. They had added the descriptions of the medicines to the pack next to the dispensing labels, so people could identify the medicines in the pack. And they supplied people with patient information leaflets (PILs) monthly. A team member described how people's prescriptions were ordered in advance, so any queries could be resolved. They made sure all items were in stock before dispensing the pack. And the pharmacist checked the packs as soon as possible after dispensing. The pharmacy had just started using master record sheets detailing the times of administration and other useful information about people's medication. These were stored in a file together, but not in a plastic wallet or similar, so in a short time these could become scruffy and untidy. And there was nowhere to record communications of any changes to people's medication. The pharmacy hadn't started using these master record cards as part of the dispensing and checking processes. So, they may have missed

opportunities to use the information on these sheets whilst dispensing and checking. For example, using the information about times of administration.

The pharmacy provided a home delivery service for a significant number of its prescriptions. At the last inspection the pharmacy didn't have an audit trail of deliveries it made or robust procedures associated with the service. Since the last inspection the pharmacy had started using an electronic system to track deliveries and obtain signatures from people on receipt. The pharmacist demonstrated the system. The pharmacy knew which deliveries were planned each day and when they were successfully delivered. It recorded CDs and fridge lines by the team member annotating this on the delivery record. The system tracked the deliveries in real time due to the application on the mobile phone used by the driver. The pharmacist described how the new system had helped with people's queries about when they would receive their medicines. And he felt it helped the pharmacy provide a more efficient service. The pharmacy had an updated SOP relating to the home delivery 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. The checked by signature boxes were completed, but not the dispensed by boxes. The pharmacist described how he would get a check on volumes measured but the dispenser didn't sign the dispensed by box. As part of the process the initials of the patient were highlighted in large print on the outer packaging or bottle lid. The pharmacy stored the pre-prepared doses appropriately in the CD cabinet, separated in a basket from other stock. These actions helped to reduce the risk of errors.

The pharmacy stored Pharmacy (P) medicines behind the pharmacy counter to avoid self-selection and so the pharmacist could oversee sales and advice given. It stored prescription only medicines (POMs) in the locality of the P medicines due to the positioning of the counter and the dispensary. These had been suitably separated since the previous inspection. The pharmacy used licensed wholesalers to obtain medicines and medical devices. The pharmacy had a date checking SOP for the team to follow. The team members completed regular date checks according to a date checking schedule. 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. The pharmacy had purchased a medical fridge since the last inspection. But it wasn't working so the medicines requiring cold storage were stored in the domestic fridge. An engineer was working on the medical fridge during the inspection but didn't manage to fix it. The pharmacy made a record of the fridge temperatures. This was seen for the last seven days and had been recorded as maximum eight degrees Celsius. But the maximum reading on the thermometer in the fridge recorded just over eight degrees Celsius. So, the thermometer and the records did not completely match. The pharmacist was aware of the issues with the fridge and recognised the importance of accurate record keeping. The pharmacy's updated SOPs detailed the processes to comply with the Falsified Medicines Directive (FMD). But the pharmacy wasn't currently verifying or decommissioning as part of the dispensing process. So, the details in the SOPs had not been followed. The pharmacy team was aware of the requirements and planned to use the function on the pharmacy's patient medication record (PMR) system. But this had not yet been actioned. The pharmacy received email notification of safety alerts and drug recalls from the Medicines and Healthcare products Regulatory Agency (MHRA). And it had printed records of actioned alerts. The team member dated and recorded the action taken.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs to provide its services. And pharmacy team members manage and use the equipment in a way which protects people's confidentiality.

Inspector's evidence

The pharmacy had hard copies of reference books available for team members to use, including the BNF, the BNF for children and Stockley's drug interactions book. They had access to the internet for up-to-date clinical information. There was evidence of electrical safety testing, with stickers attached to plugs. The pharmacy had a blood pressure meter. The pharmacist confirmed he kept records when the meter was changed or calibrated. But he couldn't find the records. The pharmacy had a range of clean, 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 such a way as 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 pharmacist and team members used NHS smartcards to access people's prescription information.

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.