General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Montague Pharmacy, Oakenhurst Road, BLACKBURN, Lancashire, BB2 1SN

Pharmacy reference: 1033107

Type of pharmacy: Community

Date of inspection: 10/03/2020

Pharmacy context

This a community pharmacy in a residential area of the town of Blackburn, Lancashire. It dispenses both NHS and private prescriptions and sells a range of over-the-counter medicines. It supplies some medicines in multi-compartment compliance packs to people living in their own homes and one local care home. And it provides a popular home delivery service. The pharmacy team offers advice to people about minor illnesses and long-term conditions.

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 identifies and manages the risks associated with the services it provides to people. And it has a set of written procedures for the team members to follow. The pharmacy mostly keeps people's private information secure. But it doesn’t always keep complete records required by law. The team members know when to raise a concern to safeguard the welfare of vulnerable adults and children. They openly discuss mistakes that they make when dispensing. But they don't regularly record details of their mistakes and why these happen. So, they may miss opportunities to improve and reduce the risk of further errors.

Inspector's evidence

The pharmacy had an open plan retail area and dispensary. The dispensary was behind the pharmacy counter. The pharmacy counter acted as a barrier between the retail area and the dispensary to prevent any unauthorised access. The pharmacist used a bench close to the pharmacy counter. This allowed him to oversee sales of pharmacy medicines.

The pharmacy had a set of written standard operating procedures (SOPs). There were SOPs for assembling and labelling prescriptions, the home delivery service and responsible pharmacist regulations. There was no index available. So, it was difficult to locate a specific SOP. The sample looked at were last reviewed in October 2019. There wasn’t a date recorded for the next review. The pharmacy defined the roles of the pharmacy team members in each documented procedure. Each of the team members had read the SOPs that were relevant to their role. But there was no record of when they had done this.

The pharmacist had recently held a discussion with the team about the current coronavirus pandemic. They discussed plans to routinely clean the pharmacy with disinfectant. And that they directed anyone who telephoned the pharmacy for advice was signposted to the NHS 111 service. The pharmacy was displaying an information notice about coronavirus on the pharmacy’s main window.

There was a process in place to highlight near miss errors made by the team when dispensing. The team members kept a tally of the number of near misses that had happened each month. And they talked about why a mistake might have happened. They explained the most common errors involved medicines that had different forms, for example, ramipril capsules and tablets. Or medicines that had different pack sizes, for example, packs of 28 or 30 tablets or capsules. The team members commonly talked about the mistakes to raise awareness and looked to take more care and double check next time they dispensed these medicines. The pharmacist completed a monthly patient safety report which was part of the requirements of the pharmacy quality scheme. And a copy of the report was kept in the dispensary for future reference. The pharmacy had a process to record and report any dispensing errors that had been handed out to people. The last error had happened over two years ago. The team members had in error, handed a person a medicine that was kept in the pharmacy’s fridge. To prevent a similar mistake happening again, the team discussed the mistake and decided only the pharmacist could hand out any medicines stored in the fridge.

The pharmacy was not displaying a responsible pharmacist notice. So, people using the pharmacy could not easily see who the responsible pharmacist on duty was. This was resolved during the inspection.

The team members explained their roles and responsibilities. And they were seen working within the scope of their role throughout the inspection. The team members accurately described the tasks they could and couldn't do in the absence of a responsible pharmacist. For example, they explained how they could only hand out dispensed medicines or sell any pharmacy medicines under the supervision of a responsible pharmacist. The pharmacy had an accuracy checking technician (ACT). The ACT was mainly responsible for completing the accuracy check of the multi-compliance compliance packs. This process was completed after the pharmacist had completed a clinical check of the corresponding prescription. But the pharmacy did not have an audit trail in place to clearly show that a prescription had been clinically checked before an accuracy check was completed. So, there was a risk that medicines could be handed to people before a pharmacist had completed a clinical check. This was discussed with the team. The pharmacist agreed that it would be beneficial to sign the corner of each prescription to confirm he had completed a clinical check before the prescription was ready for dispensing.

The pharmacy had a formal complaints procedure in place. It was not advertised for people to see. The pharmacy collected feedback from people who used it, by asking them to complete a short questionnaire. Blank questionnaires were kept on the pharmacy counter for people to self-select. The team members explained most people who used the pharmacy received a home delivery. And so, they didn't have much face-to-face contact with people. Therefore, most of the feedback they received was verbal when they spoke to people over the telephone. The pharmacy did not have any examples of any changes they had made to improve after receiving feedback from people.

The pharmacy had up-to-date professional indemnity insurance. It had an electronic responsible pharmacist record. But it wasn't completed correctly. For example, there were approximately five days in February 2020 where the pharmacist had not recorded when his responsible pharmacist duties had started or finished. The importance of keeping complete records was discussed. The pharmacy kept complete records of private prescriptions. The pharmacy kept controlled drug (CD) registers. And they were completed correctly. But the registers of CDs that were not used often were not balance checked regularly. So, the pharmacy may have some difficulty in resolving a discrepancy. A physical balance check of two randomly selected CDs matched the balance in the register. The pharmacy kept complete records of CDs returned by people to the pharmacy.

The team members were aware of the need to keep people's personal information confidential. And they had all signed confidentiality agreements when they started their employment. There was a notice in the retail area which outlined to people how the pharmacy used their personal information. The team held records containing personal identifiable information in areas of the pharmacy that only team members could access. Confidential waste was placed into a separate bin to avoid a mix up with general waste. The confidential waste was periodically destroyed using a shredder.

The pharmacist, the ACT and a pharmacy assistant had completed training on safeguarding vulnerable adults and children via the Centre for Pharmacy Postgraduate Education (CPPE). And when asked about safeguarding, the team members gave several examples of the symptoms that would raise their concerns in both children and vulnerable adults. Two team members explained how they would discuss their concerns with the pharmacist on duty, at the earliest opportunity. The team members explained the pharmacy had provided them with some basic guidance on how to manage or report a concern and the contact details of the local support teams. But the team couldn't locate it during the inspection.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy's team members support each other and manage their workload well. And they feel comfortable to raise professional concerns when necessary. The pharmacy supports its team members to complete ad-hoc training and learn from the pharmacist to help them keep their knowledge and skills refreshed and up to date.

Inspector's evidence

At the time of the inspection the pharmacist was the pharmacy's full-time resident pharmacist. He was supported by a pre-registration pharmacy graduate, a full-time ACT, a full-time pharmacy assistant and a part-time trainee counter assistant. The trainee counter assistant was observed completing some dispensing tasks that were outside the scope of her role. This was discussed with the pharmacist. The pharmacist gave assurances that he would enrol the trainee counter assistant onto an approved dispensing assistant course at his earliest opportunity. Following the inspection, the pharmacist emailed the inspector confirmation that the trainee counter assistant had been enrolled onto an approved Buttercups dispensing assistant course. The pharmacy also employed another part-time pharmacy assistant and a delivery driver who collected prescriptions from local surgeries and delivered medicines to people's homes. The team members felt they had enough support to manage their workload. They could speak to the pharmacy's superintendent pharmacist if they felt they needed additional staffing support. But they had not felt the need to do so. The team members occasionally worked additional hours to cover absences and holidays. The team made sure that no more than two team members were absent at any one time. And they did not take time off in the run up to Christmas as this was the busiest time of the year for the pharmacy. The team members were observed managing the workload well and had a manageable workflow. The pre-registration pharmacy graduate was seen asking the pharmacist for support, especially when presented with a query for the purchase of an over-the-counter medicine. They acknowledged people as soon as they arrived at the pharmacy counter.

Pharmacy team members completed training ad-hoc by reading various trade press materials. And by having regular discussions with the pharmacist about current topics. For example, they had recently talked about the current coronavirus epidemic. The team members did not receive a formal performance appraisal. They spoke with the pharmacist regularly and were comfortable in asking for additional support to help their professional development. For example, a team member had asked for additional training to learn more about dispensing CDs.

The team members felt comfortable to raise professional concerns with resident pharmacist. The pharmacy had a whistleblowing policy. And so, the team members could raise concerns anonymously. The team was set various targets to achieve. These included the number of prescription items dispensed and the number of services provided. The targets did not impact on the ability of the team to make professional judgements.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is secure, hygienic and well maintained. It has a sound-proofed room where people can have private conversations with the pharmacy's team members.

Inspector's evidence

The pharmacy was clean and professional in appearance. The building was easily identifiable as a pharmacy from the outside. The dispensary was of an appropriate size based on the volume of prescriptions the pharmacy dispensed. The benches used for dispensing were kept clear and tidy throughout the duration of the inspection. The floor spaces were mostly clear to minimise the risk of trips and falls. There was a sound-proofed and signposted consultation room with seats where people could sit down for private conversations with the team member. The room was smart and professional in appearance. There was another small private consultation area. The area had not been used for several months. There was a staff area and a large stock room at the rear of the building.

The pharmacy had clean, well-maintained sink in the dispensary for medicines preparation and a separate sink for staff use. There were male and female toilets with sinks with hot and cold running water and other facilities for hand washing. The temperature was comfortable throughout the inspection. Lighting was bright throughout the premises.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's services are easily accessible to people. The pharmacy manages its services appropriately and delivers them safely. And it supports some people to take their medicines at the right time by providing them with medicines in multi-compartment compliance packs. It suitably manages the risks associated with this service. The pharmacy sources its medicines from licenced suppliers. And it appropriately stores and manages its medicines.

Inspector's evidence

The pharmacy could be accessed via steps or a ramp from a small car park. So, people with wheelchairs and prams could easily access the pharmacy. It stocked a small range of healthcare related leaflets in the retail area, which people could select and take away with them. And it used a small section of the retail area to promote healthy living advice. The team had access to the internet to direct people to other healthcare services. The pharmacy could supply people with large print dispensing labels if needed to help people with a visual impairment. There was a hearing loop to help people with a hearing impairment, but the team was not sure if it was working properly. The pharmacist and the pre-registration graduate were fluent in Urdu which helped them in communicating with several people whose first language was Urdu.

The team members used stickers to attach to bags containing dispensed medicines, and they used these as an alert before they handed out medicines to people. For example, to highlight the presence of a fridge line or a controlled drug that needed handing out at the same time. The team members signed the dispensing labels when the dispensing and checking processes were complete. So, a robust audit trail of the process was in place. They used baskets to hold prescriptions and medicines. And they were of different colours to help the team manage the workload efficiently. The team members used 'CD' stickers to attach to the dispensed medicines bags. This system helped prevent the team members from handing out any CDs to people after their prescription had expired. Owing slips were given to people on occasions when the pharmacy could not supply the full quantity prescribed. One slip was given to the person. And one kept with the original prescription for reference when dispensing and checking the remaining quantity. The pharmacy kept records of the delivery of medicines it made to people. The records included a signature of receipt. So, there was an audit trail that could be used to solve any queries. A note was posted to people when a delivery could not be completed. The note advised them to contact the pharmacy. There was an SOP outlining the service.

The pharmacy supplied medicines in multi-compartment compliance packs for some people living in their own homes. The pharmacy managed the workload for dispensing the packs across four weeks. Because of local GP surgery guidelines, pharmacies could not order prescriptions on behalf of people. So, the ACT contacted each person who received a pack via telephone to remind them to order their prescriptions. And this was done in the second or third week of the cycle. Which gave the team members enough time to resolve any queries, such as missing items or changes in doses, and to dispense the medication. They dispensed the packs at the rear of the dispensary. This was to minimise distractions. They used people's electronic records which detailed the person's current medication and times of administration. The team members used these to check off prescriptions and confirm they were accurate. The team members kept records of conversations that they had with people's GPs. For example, if they were told about a change in directions or if a treatment was to be stopped. They

supplied the packs with backing sheets which listed the medicines in the packs and the directions. And information to help people visually identify the medicines. For example, the colour or shape of the tablet or capsule. They provided patient information leaflets with the packs.

The pharmacy dispensed high-risk medicines for people such as warfarin. But there wasn't a system to highlight people who were prescribed any high-risk medicines. And so, the team could have missed the opportunity to give people advice on how to take their medicines safely and effectively. The team members explained they would tell the pharmacist if they felt the person collecting the medicine would benefit from any additional advice or if any checks needed to be done. Such as checking if the person was having regular blood tests, or if their INR ranges needed checking if they were supplied with warfarin. The pharmacist said as the pharmacy delivered medicines to most of the people who used the pharmacy, he did not regularly have the occasion to talk to people about their medicines. However, he would speak to people via telephone if he felt the need to do so. For example, if they were prescribed a medicine for the first time. The team members were aware of the pregnancy prevention programme for people who were prescribed valproate and of the risks. They demonstrated the advice they would give people in a hypothetical situation. The team members had access to literature about the programme that they could provide to people to help them take their medicines safely. And there was a notice in the dispensary outlining information about the programme. The team had completed a check to see if any of its regular patients were prescribed valproate. And met the requirements of the programme. No one had been identified.

The pharmacy stored pharmacy medicines (P) behind the pharmacy counter. This prevented people self-selecting them. The pharmacy stored its medicines tidily in the dispensary and the team members checked the expiry dates of each medicine every three months. The team had last completed a check in December 2019. And they kept a record of the medicines that were expiring over the next six months. They also highlighted these medicines using alert stickers. At the beginning of each month the team members checked the records and removed of the medicines that were expiring in that month. No out-of-date medicines were found after a check of around twenty randomly selected medicines. The pharmacy had a robust procedure in place to appropriately store and then destroy medicines that had been returned by people. And the team had access to CD destruction kits.

The team was not scanning products or undertaking manual checks of tamper evident seals on packs, as required under the Falsified Medicines Directive (FMD). The team had not received training on how to follow the directive. Drug alerts were received via email to the pharmacist and actioned. But the pharmacy did not keep any records of the action the team members had taken. The pharmacy checked and recorded the fridge temperature ranges every day. And a sample checked were within the correct ranges. The CD cabinet was secured and of an appropriate size. The medicines inside the fridge and CD cabinets were well organised.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy's equipment is well maintained and appropriate for the services it provides.

Inspector's evidence

The pharmacy had copies of the BNF and the BNF for children for the team to use. And the team had access to the internet as an additional resource. The pharmacy used a range of CE quality marked measuring cylinders. The fridges used to store medicines were of an appropriate size. There was a blood pressure monitor kept in the consultation room. It was scheduled to be replaced every year. The team members had access to tweezers and rollers to help them dispense multi-compartment compliance packs. Prescription medication waiting to be collected was stored in a way that prevented people's confidential information being seen by members of the public. The computers were password protected to prevent any unauthorised access. The pharmacy had cordless phones, so the team members could have conversations with people in private. But some confidential material, such as repeat prescription slips, were kept on a desk in the consultation room. So, there was a risk people's personal information could be seen by unauthorised people who used the consultation room.

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.