General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: R.H. Wilson (Chemists) Ltd., 75 Whalley New Road, Bastwell, BLACKBURN, Lancashire, BB1 6JY

Pharmacy reference: 1033121

Type of pharmacy: Community

Date of inspection: 10/03/2020

Pharmacy context

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

Overall inspection outcome

✔ **Standards met**

Required Action: None

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 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 keeps most of the records it must have by law. And it keeps people's private information secure. The team members know when to raise a concern to safeguard the welfare of vulnerable adults and children. The team members openly discuss mistakes that they make when dispensing. And they make some changes to their ways of working to reduce the risk of mistakes happening again.

Inspector's evidence

The pharmacy had an open plan retail area and dispensary. 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). They were last reviewed in 2018. There were SOPs for various process such as dispensing and handling controlled drugs (CDs). There wasn’t an index available. So, it was difficult to locate a specific SOP. The pharmacy defined the roles of the pharmacy team members in each procedure. Which made clear the roles and responsibilities within the team. The team members had read and signed each SOP that was relevant to their role. But some team members had not revisited the SOPs since 2012 or 2013.

The pharmacist highlighted near miss errors made by the team when dispensing. The pharmacy had a paper near miss log onto which the team members could record the details of the near miss errors. Including the date and time of the near miss error, the type of near miss error and the reasons why it might have happened. But the team members hadn’t used the log for around four months. The team members explained they didn’t benefit from recording the details of near miss errors onto the log, and instead preferred to talk about them as soon as the pharmacist brought them to their attention. They said the most common reason for near miss errors was rushing or a lack of concentration. To improve, the team members explained they often tried to slow down the dispensing process when the pharmacy was busy. And they gave more realistic waiting times to people who wanted to wait in the pharmacy while their prescriptions were being dispensed. The most common type of near miss involved medicines that were available in different forms. Such as ramipril tablets and capsules. The team members discussed how they could reduce the frequency of similar errors happening. They decided to make sure the different forms were kept tidily on the dispensary shelves and segregated. The team members told the pharmacist immediately if they were made aware of any dispensing errors that had been handed out to people. The pharmacist explained he hadn’t been made aware of a dispensing error for several years. And the pharmacy did not keep historic records of any dispensing errors.

The pharmacy displayed the correct responsible pharmacist notice. And it was easy to see from the retail area. The team members explained their roles and responsibilities. And they were seen working within the scope of their role throughout the inspection. The pharmacist was absent from the pharmacy each day between 1pm and 2pm. 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. Each team member had the contact telephone number of the pharmacist. So,

they could contact him if they had a question or a query.

The pharmacy had a formal complaints procedure in place. And it was available for people to see via a poster in the retail area. The pharmacy collected feedback through an annual patient satisfaction survey. The team members discussed the findings of the survey with each other. The findings were generally positive. But the team couldn't provide any examples of any improvement measures following the feedback.

The pharmacy had up-to-date professional indemnity insurance. The pharmacy had a responsible pharmacist record. But the pharmacist did not always record the time his responsible pharmacist duties ended. This was not in line with requirements and the importance of keeping complete records was discussed. The pharmacy kept complete records of private prescriptions. The pharmacy kept CD registers. But the headers on each page were not completed correctly on several pages of the registers. The pharmacy team checked the running balances against physical stock when a CD was handed out or new stock had arrived. CDs that were used infrequently were not balance checked regularly. So, the team may find it difficult to resolve a discrepancy. A physical balance check of three 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. They were seen moving to the back of the dispensary to take telephone calls about people's medicines or health conditions. This was to avoid people in the retail area from overhearing the conversations. There was a privacy notice in the retail area which outlined how the pharmacy handled people's 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 responsible pharmacist 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. They explained how they would discuss their concerns with the pharmacist at the earliest opportunity. The pharmacy had some basic written guidance kept in the dispensary, on how to manage or report a concern and the contact details of the local support teams.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy team members have the appropriate qualifications and skills to provide the pharmacy's services safely and effectively. They work well together to manage their workload. And they feel comfortable to raise professional concerns when necessary. The pharmacy supports its team members to complete training, and they 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 responsible pharmacist on duty was the pharmacy owner. And he worked full-time at the pharmacy. He had owned the pharmacy for over 20 years and knew many of the people who used the pharmacy by their first names. During the inspection a part-time pharmacy assistant and a part-time pharmacy technician supported him. The pharmacy also employed two part-time delivery drivers who collected prescriptions from local surgeries and delivered medicines to people's homes, and two more part-time pharmacy assistants. The team members often 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. They were 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. They were informing people of the waiting time for prescriptions to be dispensed and taking time to speak with them if they had any queries.

The pharmacy provided the team members with ad-hoc training time. They took the time to train mainly when the pharmacy was quiet. So, they could do so without any distractions. They mainly used training books called ‘Counterskills’ to help them train. The team members also held group discussions and talked about current health topics. They had recently talked about hay fever. They brought several over-the-counter medicines that were indicated for hay fever into the dispensary. And the pharmacist explained to the team about the various scenarios in which they could be sold. The pharmacy did not have a formal appraisal process for its team members. But the pharmacist spoke openly with the team members when he felt the need to do so to help them further their professional development. For example, the pharmacist had given some additional training to a team member on the sale of cough medicines.

The team members felt comfortable to raise professional concerns with the pharmacist. The pharmacy did not have a whistleblowing policy. And so, the team members may not be able to raise concerns anonymously. The team was not set any targets to achieve.

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 highly professional in appearance. The building was easily identifiable as a pharmacy from the outside. The dispensary was of an appropriate size relative to the number of prescriptions the pharmacy dispensed. The dispensary benches were kept clear and tidy throughout the inspection. The floor spaces were mostly clear to minimise the risk of trips and falls. The retail area was well organised. The pharmacy had a private consultation room available. It was soundproofed and team members used the room to have private conversations with people. The room was signposted by a sign on the door. The room was smart and professional in appearance. There were some rooms on the first and second floor of the building. One room was used as a stock room. It was kept organised and tidy. Some other rooms were not kept tidily, and many miscellaneous items were stored on the floors. And this posed a risk of a trip or a fall.

There was a clean, well-maintained sink in the dispensary for medicines preparation and staff use. There was a toilet with a sink 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 the service. The pharmacy sources its medicines from licenced suppliers. And it appropriately stores and manages its medicines.

Inspector's evidence

The pharmacy had access via steps and a ramp to an automatic entrance door. So, people using wheelchairs or prams could easily access the premises. It stocked a wide range of healthcare related leaflets in the retail area, which people could select and take away with them. For example, leaflets on bladder weakness and the treatment of diarrhoea. 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 they had a visual impairment. The pharmacist was fluent in Urdu and Punjabi. And he was helping some people in these languages during the inspection. The pharmacist explained many people who used the pharmacy did not speak English as a first language and his fluency in Urdu and Punjabi had assisted him in helping several people improve their health.

The team members regularly 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 interactions between medicines or 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 pharmacist segregated any bags containing dispensed CDs. This 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. But the records didn't include a signature of receipt unless the pharmacy delivered a CD. So, there wasn't a complete audit trail that could be used to solve any queries. If a person was not available to receive a delivery, the driver would try again on two more occasions. If the driver was still unable to complete the delivery after three attempts, the pharmacist would contact the person to remind them to collect their medicines or arrange a suitable time for a successful delivery to be made.

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 guidelines, pharmacies in the local area were not permitted to order prescriptions on behalf of people. The pharmacy had a system in place to remind people that it was time for them to order their prescriptions. And this was done in the second or third week of the four-week 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 master sheets 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. They annotated the master sheets if there was a change to any medicines to be dispensed in the packs. For example, if there was a change to a strength or a treatment had been 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 also routinely provided patient information leaflets with the packs.

The pharmacy dispensed high-risk medicines for people such as warfarin. 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 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. 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 to prevent 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. But the pharmacy didn't keep records of the checks. The team members highlighted medicines that were expiring in the next six months. No out-of-date medicines were found after a check of around ten randomly selected medicines. They recorded the date liquid medicines were opened on the pack. So, they could check they were in date and safe to supply. 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 wasn't scanning products or undertaking manual checks of tamper evident seals on packs, as required under the Falsified Medicines Directive (FMD). Drug alerts were received via email to the pharmacy 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. But the temperature was not within range at the time of the inspection. The pharmacist explained he would investigate. Following the inspection, the pharmacist sent the inspector a copy of the fridge temperature records for the seven days after the inspection. And the temperatures were within the correct ranges. The CD cabinet was secured and of an appropriate size. The medicines inside the fridge and CD cabinet 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. The pharmacy uses its equipment to protect people's confidentiality.

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 team members had access to tweezers and rollers to assist them in dispensing 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.

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.