General Pharmaceutical Council

# Registered pharmacy inspection report

**Pharmacy Name:** Well, 53 Highfield Road, BLACKPOOL, Lancashire, FY4 2JD

**Pharmacy reference:** 1033232

**Type of pharmacy:** Community

**Date of inspection:** 16/10/2019

## Pharmacy context

This is a community pharmacy located on a high street. It is situated in the residential area of South Shore, in Blackpool. The pharmacy dispenses NHS prescriptions, private prescriptions and sells over-the-counter medicines. It also provides a range of services including seasonal flu vaccinations and substance misuse supplies. A number of people receive their medicines in multi-compartment compliance aids.

## 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 met | N/A | N/A | N/A |
| **3. Premises** | Standards met | N/A | N/A | N/A |
| **4. Services, including medicines management** | Standards not all met | 4.3 | Standard not met | The pharmacy team have not kept up to date with the date checking programme. And this has led to some expired medicines being present on the dispensary shelves. |
| **5. Equipment and facilities** | Standards met | N/A | N/A | N/A |

## Principle 1 - Governance ✔ Standards met

### Summary findings

The pharmacy team follows written procedures, and this helps to maintain the safety and effectiveness of the pharmacy's services. They are given training so that they know how to keep private information safe. But members of the pharmacy team do not always record the things that go wrong. So they may miss some opportunities to learn from them and reduce the chances of similar mistakes happening again. The pharmacy generally keeps the records it needs to by law.

### Inspector's evidence

There was an electronic set of standard operating procedures (SOPs) which were regularly updated by the head office. Members of the pharmacy team had read and completed online training to indicate they had accepted and understood the SOPs.

Dispensing errors were recorded electronically and submitted to the superintendent (SI). The most recent error involved the supply of the incorrect strength of Ozempic injections. The pharmacist had investigated the error and discussed it with the staff. An electronic software platform was used to record near miss incidents. At the end of each month this produced a patient safety report which contained the details of any trends identified. There were few incidents recorded, and the pharmacist said he did not think all errors had been recorded. The pharmacist said he would highlight mistakes to staff at the point of accuracy check and ask them to rectify their own errors. He gave examples of the action taken to help prevent similar mistakes, which included highlighting the dispensary locations of common picking errors. For example, different formulations of carbamazepine. The company shared learning between pharmacies by intranet or email messages that gave information about common errors and other possible risks. The pharmacy team would discuss the information when it was received. There was evidence of action being taken in response to these messages. For example, stickers were being used to highlight 'look alike, sound alike' medicines.

Roles and responsibilities of the pharmacy team were described in individual SOPs. The dispenser was able to explain what her responsibilities were and was clear about the tasks which could or could not be conducted during the absence of a pharmacist. Staff wore standard uniforms and had badges identifying their names and roles. The pharmacy had a complaints procedure. A notice in the retail area advised people they could discuss any concerns or feedback with the pharmacy team or head office. Complaints would be recorded and followed up by the pharmacist manager. A current certificate of professional indemnity insurance was available.

Records for the RP, private prescriptions and emergency supplies appeared to be in order. Controlled drugs (CDs) registers were maintained with running balances recorded and checked weekly. A spot check of two balances was conducted. One was found to be correct, but the other was found to have a deficit. The pharmacist promptly identified this was due to a missed entry and amended the records. Patient returned CDs were recorded in a separate register. Records of unlicensed specials did not always contain the required details of who the supply was made to and when so this information may not be available in the event of a concern or query.

An information governance (IG) policy was available. The pharmacy team had received IG training and signed confidentiality agreements. When questioned, the dispenser was able to identify how

confidential waste was segregated to be destroyed by a waste carrier. A notice was on display in the retail area about how the pharmacy handled and stored people's information.

Safeguarding procedures were included in the SOPs and the pharmacy team had completed safeguarding training. Pharmacy professional staff had completed level 2 safeguarding training. Contact details of the local safeguarding board were available. The pharmacy technician said she would initially report any concerns to the pharmacist on duty.

## Principle 2 - Staffing ✔ Standards met

### Summary findings

The pharmacy generally has enough staff to operate safely. But it is busy and the workload is challenging, which means some less urgent tasks do not always get completed. Members of the pharmacy team work well together and complete some additional training to help them keep their knowledge up to date.

### Inspector's evidence

The pharmacy team included a pharmacist, an accuracy checking technician (ACT), a pharmacy technician and two dispensers. All members of the team had completed the necessary training for their roles. The normal staffing level was a pharmacist and three other staff – this included an ACT for two days a week. Two members of the pharmacy team would work in a separate dispensing area to assemble compliance aids. Staffing levels were maintained by a staggered holiday system. Relief staff could be requested but they were not always supplied. There was a high footfall into the pharmacy which increased the workload for the dispensary staff. This meant that some tasks went amiss, such as date checking, merchandising and cleaning.

The pharmacy provided members of the team with a structured e-learning training programme based on the company's procedures and services. The training topics appeared relevant to the services provided and those completing the e-learning. Additional training modules were available to help the team's development. But these were not compulsory and were not always completed. So learning and development needs may not always be fully addressed.

The dispenser gave examples of how she would sell a pharmacy only medicine using the WWHAM questioning technique, refuse sales she felt were inappropriate and refer people to the pharmacist if needed. The pharmacist said he felt able to exercise his professional judgement and this was respected by the pharmacy team and the company. The dispenser said she felt a good level of support from the pharmacy team and was able to ask for further help if she needed it.

Appraisals were conducted by the pharmacist. Members of the pharmacy team said they thought it was a good opportunity to receive feedback about their work. And they felt able to speak about any of their own concerns. Staff were aware of the whistleblowing policy and said that they would be comfortable reporting any concerns to the head office. There were service based targets set for the pharmacy. The pharmacist said he did not feel under pressure to achieve these.

## Principle 3 - Premises ✔ Standards met

### Summary findings

The pharmacy premises are suitable for the services provided. But the dispensary is cluttered which makes work flow less effective. A consultation room is available to enable private conversations.

### Inspector's evidence

The pharmacy was cluttered with totes on the floor. Many of the totes contained stock and display materials for the retail area, which staff said they had not been able to deal with due to the workload in the dispensary. The workbenches were cluttered, which reduced the space available to the pharmacy team. A sink was available within the dispensary. Customers were not able to view any patient sensitive information due to the position of the dispensary and access was restricted by use of a gate. The temperature was controlled by the use of air conditioning units. Lighting was sufficient. The staff had access to a kitchenette and WC facilities.

A consultation room was available with access restricted by use of a lock. The space was clutter free with a desk, seating, adequate lighting, and a wash basin. The patient entrance to the consultation room was clearly signposted.

## Principle 4 - Services **Standards not all met**

### Summary findings

The pharmacy's services are easy to access. And it manages and provides them safely. But the pharmacy team does not regularly check stock medicines to make sure they are in good condition. And some expired medicines are present on the dispensary shelves, which may increase the risk of them being supplied to people. Members of the team do not always know when they are handing out higher-risk medicines. So they may not always check that the medicines are still suitable, or give people advice about taking them.

### Inspector's evidence

Access to the pharmacy was level via a single door and was suitable for wheelchair users and there was wheelchair access to the consultation room. Pharmacy practice leaflets gave information about the services offered and information was also available on the website. Pharmacy staff were able to list and explain the services provided by the pharmacy. The pharmacy opening hours were displayed at the entrance and a range of leaflets provided information about various healthcare topics.

The pharmacy had a delivery service. Deliveries were segregated after their accuracy check and a delivery sheet was used to obtain signatures from the recipient to confirm delivery. Unsuccessful deliveries would be returned to the pharmacy and a card posted through the letterbox indicating they had attempted a delivery. CDs were recorded on a separate delivery sheet for individual patients and a signature was obtained to confirm receipt.

The pharmacy team initialled dispensed by and checked by boxes on dispensing labels to provide an audit trail. They used dispensing baskets to separate individual patients' prescriptions to avoid items being mixed up and the baskets were colour coded to help prioritise dispensing. Owing slips were in use to provide an audit trail if the full quantity could not be immediately supplied. The pharmacist performed a clinical check of all prescriptions and then signed the prescription form to indicate this had been completed. When this had been done an accuracy checker was able to perform the final accuracy check.

Some prescriptions were dispensed by an automated hub as part of the company's central fulfilment programme. Consent to send prescriptions to another site within the company was not routinely obtained. So people may not always know their information is being shared in this way. Prescriptions for the hub were labelled electronically and the pharmacist would then complete the accuracy and clinical check on the information that had been entered. This was then transmitted to the hub, and the PMR indicated any items which could not be dispensed. This included items out of stock, not stocked, or CD and fridge items. The process was auditable by use of a personal log in to identify who had labelled the prescription and who performed the accuracy and clinical check. Dispensed medicines were received back from the hub within 48 hours bagged for individual patients. These were in a sealed tote that clearly identified that it contained dispensed medicines. The bagged medicines were then matched up against the prescription forms and did not need to be accuracy checked by the pharmacist. Any other items not dispensed by the hub were dispensed and checked in the branch.

Dispensed medicines awaiting collection were segregated away from the dispensing area on a collection shelf using a numerical retrieval system. Prescription forms were retained, and stickers were used to clearly identify when fridge or CD safe storage items needed to be added. When people came to collect

their medicines, the pharmacy team would search for a patient name on a handheld electronic device. This had a record of the storage location of the person's medicine. Confirmation of the person's address would be obtained by the member of the pharmacy team before they scanned the shelf and the barcode on the bag. This would need to match the recorded data otherwise a red warning would appear indicating it was the incorrect medicines. This helped to reduce the likelihood of a supply to the incorrect person.

Schedule 3 CDs were highlighted so that staff could check prescription validity at the time of supply. But, schedule 4 CDs were not. So there was a risk that these medicines could be supplied after the prescription had expired. High-risk medicines (such as warfarin, lithium and methotrexate) were not routinely highlighted. So the pharmacy team were not always aware when they were being handed out in order to check that the supply was suitable for the patient. The staff were aware of the risks associated with the use of valproate during pregnancy. Educational material was available to hand out when the medicines were supplied. The pharmacist said he had completed an audit and would speak to any patients who were at risk to make them aware of the pregnancy prevention programme. But there were currently no patients that met the risk criteria.

Some medicines were dispensed in multi-compartment compliance aids. An assessment was completed by the pharmacist to check if the person was suitable to receive their medicines in a compliance pack. A record sheet was kept for each patient, containing details of their current medication. Any medication changes were confirmed with the GP surgery before the record sheet was amended. Hospital discharge sheets were sought, and previous records were retained for future reference. Disposable equipment was used to provide the service, and the compliance aids were labelled with medication descriptions and a dispensing check audit trail. Patient information leaflets (PILs) were not routinely supplied. So people may not have all of the information they need to take the medicines safely.

The pharmacy offered blistered medication to care homes. A re-order sheet was provided to the pharmacy and it contained details about the medicines required, medicine changes and any handover notes for the pharmacy. When prescriptions were received from the GP surgery they would be compared to the re-order sheet to confirm all medicines had been received back. Any queries were written onto a query sheet and chased up with the GP surgery. A copy of the query sheet was provided to the care home upon delivery of the medicines. Some of the medicines were dispensed into disposable compliance aids and a dispensing and checking signature was written onto the seal. PILs were provided to the care home. A delivery sheet was used and signed by the care home.

Medicines were obtained from licensed wholesalers, with unlicensed medicines sourced from a specials manufacturer. The pharmacy was not yet meeting the safety features of the falsified medicine directive (FMD), which is now a legal requirement. Equipment was installed but the pharmacy team had yet to commence routine safety checks of medicines. Stock was date checked on a 3-month rotating cycle. Records of what had been checked were electronically maintained. And short dated stock was highlighted using a sticker and recorded for it to be removed at the start of the month of expiry. But the pharmacy team said they had not been able to keep up to date with the date checking schedule for a number of months. A spot check of the dispensary stock found three different medicines which had expired and had not been highlighted with a sticker. Liquid medication had the date of opening written on.

Controlled drugs were stored appropriately in the CD cabinet, with some segregation between current stock, patient returns and out of date stock. CD denaturing kits were available for use. There were clean medicines fridges, each with a thermometer. The minimum and maximum temperatures were being recorded daily. Some of the records over the last 3 months indicated the maximum temperature for one of the fridges was exceeding the maximum temperature of 8C without any further investigation.

The current temperature remained within range during the inspection and the pharmacist said the thermometer may have not been reset correctly. Patient returned medication was disposed of in designated bins located away from the dispensary. Drug alerts were received electronically from the head office. Alerts were actioned  and a record was made showing who responded to the alert and when.

## Principle 5 - Equipment and facilities ✔ Standards met

### Summary findings

The pharmacy's team members have access to the equipment they need for the services they provide. And they maintain the equipment so that it is safe to use.

### Inspector's evidence

The staff had access to the internet for general information. This included access to the BNF, BNFc and drug tariff resources. Electrical equipment appeared to be in working order. According to the stickers attached, electrical equipment had been PAT tested in September 2019. There was a selection of liquid measures with British Standard and Crown marks. Separate measures were designated and used for methadone. The pharmacy also had counting triangles for counting loose tablets including a designated tablet triangle for cytotoxic medication. Equipment was kept clean by the pharmacy team.

Computers were password protected and screens were positioned so that they weren't visible from the public areas of the pharmacy. A cordless phone was available in the pharmacy which allowed the staff to move to a private area if the phone call warranted privacy. The consultation room was used appropriately; patients were offered its use when requesting advice or when counselling was required. Substance misuse clients were directed to the use of the consultation room to provide privacy.

## 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. |