General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: F. Crossley (Chemists) Ltd., 273 Lytham Road, BLACKPOOL, Lancashire, FY4 1DP

Pharmacy reference: 1033235

Type of pharmacy: Community

Date of inspection: 20/11/2019

Pharmacy context

This is a community pharmacy situated on a high street. It is located on a major route through South Shore, in the town of 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	1.7	Good practice	Members of the team are given training so that they know how to keep private information safe.
		1.8	Good practice	The pharmacy team know the signs of concern to look out for and can provide examples of how they have safeguarded people
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 does not always store controlled drugs in accordance with current legal requirements.
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. The pharmacy generally keeps the records it needs to by law. And members of the team are given training so that they know how to keep private information safe. They know the signs of concern to look out for and can provide examples of how they have safeguarded people. Members of the pharmacy team record things that go wrong and discuss them to help identify learning and reduce the chances of similar mistakes happening again.

Inspector's evidence

There was a current set of standard operating procedures (SOPs) which were issued in February 2019. Members of the pharmacy team had signed to say they had read and accepted the SOPs.

Dispensing errors were recorded on a standardised form. A recent error involved the wrong formulation of Fostair inhaler. The pharmacist had investigated the error and shared his findings with the pharmacy team. Near miss errors were recorded on a paper log. The pharmacist said he would discuss the records with the pharmacy team. He would also highlight mistakes to staff at the point of accuracy check and ask them to rectify their own errors. But discussions about the records were not recorded to help identify underlying factors. So there may be some missed learning opportunities. He gave examples of action taken to help prevent similar mistakes. For example, moving amitriptyline and amlodipine away from each other to help prevent picking errors.

Roles and responsibilities of the pharmacy team were described in individual SOPs. A 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 responsible pharmacist (RP) had their notice displayed prominently. The pharmacy had a complaints procedure. This was described in the practice leaflet and it advised people they could give feedback to members of the pharmacy team. Any complaints would be recorded to be followed up by the pharmacist. A current certificate of professional indemnity insurance was on display.

Records for the RP, private prescriptions, emergency supplies and unlicensed specials appeared to be in order. Controlled drugs (CDs) registers were maintained with running balances recorded. Three balances were randomly checked. Two were found to be correct. One was found to have an extra 120 tablets in stock. Following the inspection, the pharmacist confirmed it was due to a missed entry and he had amended the records. Patient returned CDs were recorded in a separate register.

An information governance (IG) policy was available. The pharmacy team had completed GDPR training and had signed confidentiality agreements. When questioned, a dispenser was able to describe how confidential waste was segregated and destroyed using the on-site shredder. A privacy notice was on display and described how patient data was handled.

Safeguarding procedures were in place. The pharmacy team had completed in-house safeguarding training, and the pharmacist had completed level 2 safeguarding training. Contact details of the local safeguarding board were on display within the dispensary. A dispenser said she would initially report

any concerns to the pharmacist on duty. The pharmacy team gave examples of safeguarding concerns they had raised. One example involved concerns about a vulnerable adult being raised with their GP. This person was reviewed by the GP on the same day.

Principle 2 - Staffing ✔ Standards met

Summary findings

There are enough staff to manage the pharmacy's workload and they are appropriately trained for the jobs they do. Members of the pharmacy team complete some additional training to help them keep their knowledge up to date.

Inspector's evidence

The pharmacy team included a pharmacist manager, four dispensers and a medicine counter assistant (MCA). All members of the team had completed the necessary training for their roles. The normal staffing level was a pharmacist and two to three staff. The volume of work appeared to be managed. Staffing levels were maintained by part-time staff and a staggered holiday system. Relief staff could be requested from other branches but were not often needed.

Members of the pharmacy team completed some additional training, for example they had recently completed a training pack about Children’s oral health. Training records were kept showing that ongoing training was up to date. But further training was not provided in a structured or consistent manner. So learning needs may not always be fully addressed.

A dispenser gave examples of how she would sell a pharmacy only medicine using the WWHAM questioning technique, refuse co-codamol 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 superintendent (SI) and the pharmacy team. A dispenser said she felt able to ask for further help if she needed it and got a good level of support from the pharmacist.

Appraisals were conducted by the pharmacy manager each year. A dispenser said she felt that the appraisal process was a good chance to receive feedback and discuss her work. Staff were aware of the whistleblowing policy and said that they would be comfortable reporting any concerns to the manager or SI. There were no service-based targets set by the pharmacy.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are suitable for the services provided. A consultation room is available to enable private conversations.

Inspector's evidence

The pharmacy was clean and tidy, and appeared adequately maintained. The size of the dispensary was sufficient for the workload. 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 electric heaters. Lighting was sufficient. The staff had access to a kettle, microwave, and WC facilities.

A consultation room was available with access restricted by use of a lock. The space was clutter free with a computer, 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 them safely. But it does not always store medicines securely. And members of the pharmacy team do not always know when they are handing out higher-risk medicines. So they might not always be able to 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. There was also wheelchair access to the consultation room. Pharmacy practice leaflets gave information about the services offered. Pharmacy staff were able to list and explain the services provided by the pharmacy. If the pharmacy did not provide a particular service staff were able to refer patients using a signposting folder. The pharmacy opening hours were displayed 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 recorded on a delivery sheet. Unsuccessful deliveries would be returned to the pharmacy and a card posted through the letterbox indicating the pharmacy 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. 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. Dispensed medicines awaiting collection were kept 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. Staff were seen to confirm the patient's name and address when medicines were handed out.

The pharmacist said the PMR would alert the pharmacy team about any electronic prescriptions for schedule 3 and 4 CDs which were due to expire. And he would highlight any paper prescriptions which contained a schedule 3 or 4 CD to remind staff to check the date of the prescription. 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 would speak to any patients who were at risk to make them aware of the pregnancy prevention programme, which would be recorded on their PMR. He said he was not aware of any current patients who met the risk criteria.

Some medicines were dispensed in multi-compartment compliance aids. People requesting this were referred to the GP to assess whether they were suitable for their medicines to be dispensed into compliance aids. 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 routinely supplied.

The pharmacy provided a flu vaccination service using a patient group directive (PGD). The pharmacist had completed a declaration of competence to say he had the necessary training to meet PGD requirements. The current PGD was not available, which increased the risk of a supply outside its requirements. Records of vaccinations were kept, and the GP was informed about vaccinations.

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. A date checking matrix was signed by staff as a record of what had been checked, and shelving was cleaned as part of the process. Short dated stock was highlighted using a highlighter pen. Liquid medication had the date of opening written on.

Controlled drugs were stored inside the CD cabinets with clear segregation between current stock, patient returns and out of date stock. But the cabinets did not meet legal requirements. 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 and records showed they had been in range for the last 2 months. Patient returned medication was disposed of in designated bins located away from the dispensary. Drug alerts were received by email from the MHRA. Alerts were printed, action taken was written on, initialled and signed before being filed in a folder.

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. All electrical equipment appeared to be in working order. According to the stickers attached, electrical equipment had been PAT tested in June 2014. 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. A liquid pump was used for dispensing methadone. It was kept clean and a calibration log was completed each day for two volumes.

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.

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.