General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Normoss Pharmacy Ltd, 112 Normoss Road, BLACKPOOL, Lancashire, FY3 8QP

Pharmacy reference: 1033241

Type of pharmacy: Community

Date of inspection: 18/09/2019

Pharmacy context

This is a community pharmacy located on a parade of shops. It is situated in the residential area of Normoss, north-east of Blackpool town centre. The pharmacy dispenses NHS prescriptions, private prescriptions and sells over-the-counter medicines. It also provides a seasonal flu vaccination service. 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	Multi-compartment compliance aids are left unsealed for long periods of time. So the pharmacy cannot demonstrate the medicines remain fit for purpose. The pharmacy does not have a thermometer to monitor the medicines fridge. So it cannot provide assurance that medicines requiring refrigeration are appropriately stored and fit for purpose.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance ✔ Standards met

Summary findings

The pharmacy team has written procedures to help it work effectively. But one member of team has not read the procedures. So they may not fully understand their responsibilities. The pharmacy 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 record things that go wrong. But they do not review the records so they may miss some learning opportunities.

Inspector's evidence

There was a set of standard operating procedures (SOPs) which were issued in June 2017.Their stated period of review was every 2 years, but they had not yet been reviewed. So they may not always reflect current practice. Most of the pharmacy team had signed to say they had read and accepted the SOPs. But a trainee dispenser had not. And she was not clear about what could or could not be completed during the absence of a pharmacist. The pharmacist said he would retrain her on the SOPs.

Dispensing errors were recorded on a standardised form. The most recent error involved supplying the incorrect strength of losartan tablets. The pharmacist had investigated the error and identified that it occurred during a time of multiple staff absences. The pharmacist said in future he would make better arrangements to cover planned absences. A paper log was available to record near miss incidents. The pharmacist said each dispenser had their own log, but they were not available to view. There was no collective review of the mistakes made, which may prevent underlying factors from being identified. 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 an example that he had spoken to the staff about different formulations of inhalers to help prevent near miss errors.

Roles and responsibilities of the pharmacy team were described in individual SOPs. When questioned, the trainee dispenser was able to describe what her responsibilities were. The responsible pharmacist (RP) had their notice displayed prominently. 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. Complaints would be recorded and followed up by the pharmacy manager or head office. A current certificate of professional indemnity insurance was on display in the pharmacy.

Controlled drugs (CDs) registers were maintained with running balances recorded. The balance of Longtec 5mg MR tablets and Zomorph 10mg MR capsules were checked and both found to be accurate. Patient returned CDs were recorded in a separate register. Records for the RP, private prescriptions, emergency supplies and unlicensed specials appeared to be in order.

An information governance (IG) policy was available and this had been read by the pharmacy team. The pharmacy team members had also signed a confidentiality agreement. When questioned, the trainee dispenser was able to describe how confidential waste was segregated to be destroyed using an on-site shredder. A privacy notice in the retail area provided information about how the company handled and stored people's information.

Safeguarding procedures were included in the SOPs, but some members of the pharmacy team had not read these. And they had not completed any additional training. So they may not always be able to

identify signs that indicate cause for concern. The pharmacist said he had completed level 2 safeguarding training. Contact details of the local safeguarding board were in the dispensary. The counter assistant said she would initially report any concerns to the pharmacist on duty.

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. But this is not structured so learning needs may not always be identified or addressed.

Inspector's evidence

The pharmacy team included a pharmacist manager, two dispensers – one of whom was in training, and two medicine counter assistants (MCA). The pharmacy team were appropriately trained or on accredited training programmes. The normal staffing level was a pharmacist and two to three members of 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 also be requested from nearby branches.

Members of the pharmacy team completed some additional training. For example, they completed training booklets received through the post. A counter assistant said she would read these when it was quiet. But records of the activity were not kept, and further training was not provided in a structured or consistent manner.

The trainee 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 trainee dispenser said she received a good level of support from the pharmacist and felt able to ask for further help if she needed it. Members of the pharmacy team had not had appraisals.

Staff were aware of the whistleblowing policy and said that they would be comfortable reporting any concerns to the manager or SI. The pharmacist said he was set performance-based targets. But 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. 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 confidential 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 kettle, microwave, and WC facilities.

A post office formed part of the dispensary. The pharmacist said the post office staff had signed a confidentiality agreement. Post office operations were only conducted during the pharmacy's opening hours.

A consultation room was available with access restricted by use of a lock. There was a desk, seating, adequate lighting, and a wash basin. It was also used as a kitchenette, which detracted from the professional appearance people expect of a consultation area. And it may not always provide a high level of hygiene required for invasive procedures, such as flu vaccinations.

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

Summary findings

The pharmacy's services are easy to access. And it generally manages them to allow them to be provided safely. But medicines in compliance aids are sometimes left unsealed and unlabelled for long periods of time. So there may be more risk of things going wrong. Members of the pharmacy team do not always know when they are handing out higher-risk medicines. So they might 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 an automatic door, and an external purpose-built ramp enabled access for wheelchair users. There was also wheelchair access to the consultation room. A practice leaflet provided 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. A range of leaflets provided information about various healthcare topics.

A repeat prescription service was offered where patients would contact the pharmacy to order their medication. Some patients were on a managed repeat system where the pharmacy would contact the patient in advance to ask if they required any medication. A record of requested medication was kept, and any missing items were queried with the GP surgery.

The pharmacy had a delivery service. Deliveries were segregated after their accuracy check and a sheet was used to record the deliveries that had been made. 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 and the baskets were colour coded to help prioritise dispensing. Dispensed medicines awaiting collection were segregated away from the dispensing area on a collection shelf using an alphabetical 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.

Schedule 3 CDs were highlighted so that staff could check prescription validity at the time of supply. However; 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 may not be aware when they are being handed out in order to check that the supply is 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 had spoken to patients who were at risk and made them aware of the pregnancy prevention programme, which was recorded on their PMR.

Some medicines were dispensed in multi-compartment compliance aids. The pharmacist said some patients were assessed by their GP about suitability for this service. But a number of patients who received a monthly supply had not been assessed. So the pharmacy may not be able to demonstrate whether this service is appropriate for all of the patients. 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 information was sought, and previous records were retained for future reference. Disposable equipment was used to provide the service. A number of compliance aids were present which were left unsealed whilst they were waiting to be checked by the pharmacist. The staff said these had been assembled one or two days ago. So the pharmacy cannot provide assurances these medicines remain fit for purpose. During this time, the compliance aids did not contain dispensing labels and did not contain all of the required labelling information, such as batch numbers and expiry dates. This is not in line with current legal requirements and may increase the risk of error. Once dispensing labels had been affixed, they were labelled with medication descriptions and a dispensing check audit trail. The compliance aids were then checked and sealed by the pharmacist. Patient information leaflets (PILs) were not routinely supplied. This is a legal requirement and without the leaflets people may not always have all the information they might need.

Medicines were obtained from licensed wholesalers, with unlicensed medicines sourced from a specials manufacturer. The pharmacy did not have the equipment needed to be able to meet the safety features of the falsified medicine directive (FMD), which is now a legal requirement. So the pharmacy team had yet to commence routine safety checks of medicines. The pharmacist said stock was date checked on a monthly basis. But this was not recorded when it was completed. So there is a risk that some medicines may be overlooked. Short dated stock was highlighted using a sticker. Liquid medication did not always have the date of opening written on, such as morphine sulphate oral solution which expired 3 months after opening. A spot check of medicines did not find any out of date stock.

There was a clean fridge. But there was no thermometer available to monitor the temperature. The pharmacist said this had broken on the day prior to inspection. There was no other method to monitor the current fridge temperatures.

Controlled drugs were stored appropriately in the CD cabinet, with clear segregation between current stock, patient returns and out of date stock. CD denaturing kits were available for use. 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 use it in ways that protect confidentiality.

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. There were no stickers attached to indicate they had been PAT tested. 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.

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.