General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: I.G. Todd Ltd, 135-139 Burnley Road, Padiham, BURNLEY, Lancashire, BB12 8BA

Pharmacy reference: 1033304

Type of pharmacy: Community

Date of inspection: 27/11/2019

Pharmacy context

The pharmacy is on a high street in Padiham. Pharmacy team members dispense NHS prescriptions and sell a range of over-the-counter medicines. And, they offer services including medicines use reviews (MURs) and the NHS New Medicines Service (NMS). The pharmacy offers remote access to consultations with an online GP. Pharmacy team members supply some medicines to people in multi-compartment compliance packs and deliver medicines to people in their own homes.

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 generally identifies and manages the risks to its services. It protects people's confidential information. And it keeps the records it must by law. Pharmacy team members know how to help safeguard the welfare of children and vulnerable adults. They record and discuss mistakes that happen during dispensing. And they use this information to learn and reduce the risk of further errors. But they may miss opportunities to improve as they do not always collect information about the causes of these mistakes. The pharmacy team members follow written procedures to complete their required tasks. But the pharmacy doesn't regular update these procedures. And the procedures don't always reflect how pharmacy team members carry out their tasks. So, there may be confusion about the most effective way to deliver pharmacy services.

Inspector's evidence

The pharmacy had a set of standard operating procedures (SOPs) in place. The sample checked were last reviewed in 2016. And the next review was scheduled for 2017. This was discussed with the superintendent pharmacist. He said he was aware of his delay in reviewing the procedures. And, he gave an assurance that they would be reviewed as soon as possible. Pharmacy team members had read and signed the SOPs after the last review in 2016. And, their roles were defined in each procedure. The pharmacy had changed some of the template SOPs to reflect how the processes were carried out in the pharmacy. One example was changes to the procedure for dealing with prescriptions that had not been collected by people. But other documented procedures had not been changed to reflect recent changes to some processes. One example were the changes the pharmacy had made to the dispensing process to incorporate the requirements of the falsified medicines directive (FMD).

The pharmacy provided access to a private online GP service from its consultation room. People booked their appointment online with MedicSpot and they directed people to the pharmacy for a GP consultation. The pharmacy didn't have any involvement with the reason for the consultation request. The pharmacist explained often it was if the person could not get a GP appointment. The pharmacy was aware that the prescribing service followed clinical practice guidelines. And did not prescribe medicines that were open to abuse. MedicSpot had systems in place to mitigate people setting up multiple accounts with them. Each consultation was via a live video link with a GP. The person was invited in to the consultation room. In the room, the pharmacy provided a computer and various pieces of diagnostic equipment, all of which were connected to the computer. These included a stethoscope, a blood pressure monitor, a pulse oximeter and a thermometer. Pharmacy team members explained that people were asked to leave all pieces of equipment they had used on the desk after their consultation so they could be cleaned and prepared ready for the next person. The pharmacy had a procedure in place to instruct pharmacy team members about how to guide people through a consultation. The procedure also detailed which symptoms could not be treated by the online GP, such as severe chest pain, heavy bleeding or unrelenting high fever. And which types of patients, such as children under 5 years old. These people would be referred to their usual GP or to hospital. The online GPs obtained people's consent to share the consultation report with the person's own GP. And they made a professional judgement of the appropriateness of any supply if the person refused to consent. People requesting the service were also shown a card which detailed the symptoms that could be treated by the service. And the medicines that would not be prescribed by the service, such as any schedule two and most schedule three controlled drugs and other high-risk medicines, like buspirone. The SI

explained that the prescribers were GPs and were UK registered and located in the UK. And he checked the credentials of any prescribers he was not familiar with. If the online GP generated a prescription, these were signed electronically and emailed to the pharmacy to be dispensed. Several examples of prescriptions were seen. And they contained all the legally required information. And no high-risk medicines had been prescribed.

The pharmacist highlighted and recorded near miss errors made by the pharmacy team when dispensing. Pharmacy team members recorded their own mistakes. They discussed the errors made. And they discussed why mistakes had happened with the pharmacist and each other. They did not record much detail about why a mistake had happened. This was discussed. And pharmacy team members said the most common cause of mistakes was rushing while they were busy because they were sometimes distracted by thinking about their workload. They had discussed this recently. And they had reinforced the need to perform a final check of their work before they signed the dispensing labels and passed the prescription to the pharmacist for a final check. The pharmacist analysed the data collected about mistakes approximately every month. But he did not record his analysis. He said he looked at the data to establish patterns of medicines being involved in errors. Then discussed the patterns with the team. And pharmacy team members made changes to help reduce the risk of recurrence. One example was the team separating normal and prolonged release formulations of carbamazepine to help prevent picking errors. The pharmacist did not analyse the data for patterns of causes. The pharmacy had a clear process for dealing with dispensing errors that had been given out to people. It recorded incidents using a template reporting form. Errors were discussed amongst the team. And changes were made to help prevent the mistake happening again. A recent example was an error where rizatriptan had been dispensed instead of risedronate. Pharmacy team members had identified that the medicines were already stored in different places in the pharmacy. So, they had attached warning stickers to the shelves in front of the products to highlight the risks when dispensing. The records of errors kept by the pharmacy did not include much, if any, information about the causes discussed. Or document the changes pharmacy team members had made to prevent recurrence, to help with reflection in the future.

The pharmacy had a procedure to deal with complaints handling and reporting. It had a poster available for customers in the retail area which clearly explained the company's complaints procedure. It collected feedback from people by using questionnaires. Pharmacy team members could not give any examples of any changes made in response to feedback. They said common feedback was that the pharmacy did not have somewhere to speak to pharmacy team members privately, despite the pharmacy having a consultation room. This was discussed. And, pharmacy team members appreciated that although they had a private consultation room, the room was not clearly visible or signposted from the pharmacy counter.

The pharmacy had up-to-date professional indemnity insurance in place. It had a certificate of insurance displayed. The pharmacy kept controlled drug (CD) registers complete and in order. It kept running balances in all registers. And these were audited against the physical stock quantity after each entry. They did not regularly audit the registers of CDs used infrequently. The pharmacy did not stock methadone. It kept and maintained a register of CDs returned by people for destruction. And this was complete and up to date. The pharmacy maintained a responsible pharmacist record electronically. And it was complete and up to date. The pharmacist displayed their responsible pharmacist notice to people. Pharmacy team members monitored and recorded fridge temperatures daily. They kept private prescription records in a paper register, which was complete and in order. They recorded emergency supplies of medicines electronically. They recorded any unlicensed medicines supplied, which included the necessary information in the samples seen.

The pharmacy kept sensitive information and materials in restricted areas. It collected confidential waste in a dedicated, locked bin. The bin was emptied periodically, and the contents removed for secure destruction by an external contractor. Pharmacy team members had been trained to protect privacy and confidentiality. They had completed a training workbook in 2018. Pharmacy team members were clear about how important it was to protect confidentiality. And there was a procedure in place detailing the requirements under the General Data Protection Regulations (GDPR). During the inspection, the inspector observed pharmacy team members using a screened area of the pharmacy counter to talk to people discreetly about their medicines. They were also observed asking people to confirm various elements of their identity before handing out prescriptions, to make sure prescriptions were given to the right people. Pharmacy team members said they would also use the consultation room to have private discussions with people, if necessary.

When asked about safeguarding, a dispenser gave some examples of symptoms that would raise their concerns in both children and vulnerable adults. They explained how they would refer to the pharmacist for advice. The pharmacist said they would assess the concern. And would refer to local safeguarding teams or the patient's GP. The pharmacy had an SOP in place informing pharmacy team members about what to do in the event of a concern. The pharmacist had completed training on safeguarding in 2018. But, other pharmacy team members had not completed any formal training. They explained they had been trained verbally by the pharmacist and by reading the procedure. And by drawing on experience from other roles. The online GP prescribing service followed 'consulting with children's policies'.

Principle 2 - Staffing ✔ Standards met

Summary findings

Pharmacy team members have the right qualifications and skills for their roles and the services they provide. They feel comfortable making suggestions to help improve pharmacy services. Pharmacy team members complete ad-hoc training. And they learn from the pharmacist and each other to help develop their knowledge. But they are sometimes unable to find time during work to access the training materials available to help keep their knowledge and skills up to date.

Inspector's evidence

At the time of the inspection, the pharmacy team members present were the superintendent pharmacist (SI), two dispensers and a medicines counter assistant (MCA). The MCA had also completed training to be able to unpack and put away medicines in the dispensary. Pharmacy team members completed training ad-hoc by reading various trade press materials. And by having regular discussions with the pharmacist and colleagues about current topics. They explained they also had access to online training modules. But they rarely found time to undertake training at work. They explained this was because a colleague had left in March 2019 and had not been replaced. This was discussed with the SI. And, he gave an assurance that he would review the staffing levels in the pharmacy to help team members find time to develop their skills and knowledge. The pharmacy did not have a formal appraisal or performance review process. Pharmacy team members said they raised any learning needs with the SI or colleagues informally. And, he would teach them or signpost them to relevant resources.

A dispenser explained she would raise professional concerns with the superintendent pharmacist (SI). She felt comfortable raising a concern. And confident that her concerns would be considered, and changes would be made where they were needed. The pharmacy did not have a whistleblowing policy. Pharmacy team members communicated with an open working dialogue during the inspection. They explained about a change they had made to the process for preparing prescriptions for delivery following sharing of ideas. Previously, pharmacy team members put away the stock order on a morning before preparing the prescriptions for delivery that day. This meant the delivery driver had very little to do in the mornings. And he was often very busy in the afternoons. This had been discussed. They had changed the process so that deliveries for the day were prepared first. Then they put away the stock order. This meant that the delivery driver’s workload was more evenly spaced throughout the day. And meant he had more capacity to deal with any emergency deliveries. The pharmacy did not ask the team to achieve any targets.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean and properly maintained. It provides a suitable space for the services provided. And, it has a room where people can speak to pharmacy team members privately.

Inspector's evidence

The pharmacy was clean and well maintained. All areas of the pharmacy were tidy and well organised. And the floors and passage ways were free from clutter and obstruction. There was a safe and effective workflow in operation. And clearly defined dispensing and checking areas. It kept equipment and stock on shelves throughout the premises. The pharmacy had a first floor, which was used for storage. And, it had a private consultation room available. Pharmacy team members used the room to have private conversations with people. The room was signposted by a sign on the door. It was not clearly signposted from the main pharmacy retail counter where people handed in their prescriptions and collected their medicines. And, where people usually made first contact with pharmacy team members about their health after the came in to the pharmacy.

There was a clean, well maintained sink in the dispensary used for medicines preparation. There was a toilet, which provided a sink with hot and cold running water and other facilities for hand washing. Heat and light in the pharmacy was maintained to acceptable levels. The overall appearance of the premises was professional, including the exterior which portrayed a professional healthcare setting. The professional areas of the premises were well defined by the layout and well signposted from the retail area.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's services are easily accessible to people. And the pharmacy has systems in place to help provide its services safely and effectively. Pharmacy team members take steps to identify people taking high-risk medicines. And they provide these people with advice to help them take their medicines safely. Pharmacy team members dispense medicines into devices to help people remember to take them correctly. And they generally manage this service well. But they could improve the record keeping associated with this service. The pharmacy team members source, store and manage medicines safely.

Inspector's evidence

The pharmacy was accessed through two doors from the street. One had stepped access with a handrail. The other provided level access to the pharmacy. Pharmacy team members explained they would use written communication with someone with a hearing impairment. And, they made sure they spoke clearly so people could lipread during conversations. They were able to provide large-print labels and instruction sheets for people with visual impairment.

Pharmacy team members signed the dispensed by and checked by boxes on dispensing labels. This was to maintain an audit trail of staff involved in the dispensing process. The pharmacy team used dispensing baskets throughout the dispensing process to help prevent prescriptions being mixed up. The pharmacist counselled people receiving prescriptions for valproate if appropriate. And, they checked if the person was aware of the risks if they became pregnant while taking the medicine, giving them appropriate advice and counselling. The pharmacy had a supply of printed information material to give to people to help them understand the risks. The pharmacy supplied medicines in multi-compartment compliance packs when requested. It attached labels to the packs, so people had written instructions of how to take the medicines. Pharmacy team members added descriptions of what the medicines looked like, so they could be identified in the pack. And, they provided people with patient information leaflets about their medicines each month. The pharmacy team documented any changes to medicines provided in packs by making a new master record sheet for the patient. They kept the old record sheet. But they did not mark the old sheet to make it clear it had been superseded. And, in some examples seen, it was not clear which was the most up to date master record. Some packs seen during the inspection were not fully labelled because they were in the process of being prepared. This was discussed with pharmacy team members. And, they appreciated the importance of fully labelling the packs before inserting the medicines in to the compartments. The pharmacy delivered medicines to people. It recorded the deliveries made. But, the delivery driver only asked people to sign for receipt of controlled drugs delivered. People were not asked to sign for other items. The delivery driver left a card through the letterbox if someone was not at home after he had tried to deliver twice. These items were returned to the pharmacy. And, the delivery driver raised them with the pharmacist if he was unable to successfully deliver the prescription the following day.

The pharmacy obtained medicines from five licensed wholesalers. It stored medicines tidily on shelves. And all stock was kept in restricted areas of the premises where necessary. It had adequate disposal facilities available for unwanted medicines, including controlled drugs (CDs). Pharmacy team members kept the CD cabinets tidy and well organised. And, out of date and patient returned CDs were segregated. The inspector checked the physical stock against the register running balance for three products. And they were found to be correct. The pharmacy had the necessary equipment in place to

scan medicines and to comply with the Falsified Medicines Directive (FMD). Pharmacy team members were regularly scanning medicines to check for falsified products. And, to decommission packs from the pharmacy supply chain. They had received training on the requirements of FMD. But the pharmacy's documented procedures had not been updated to incorporate the changes made to the dispensing process to accommodate FMD. The medicines counter assistant (MCA) gave sound examples of the high-risk items she would restrict when requested by people, such as co-codamol. And, she gave clear examples of requests she would immediately refer to the pharmacist, such as requests for sumatriptan. She was unsure of the quantities of co-codamol and paracetamol she was legally allowed to sell over the counter. But she said she would always check with the pharmacist if people asked for more than one pack at a time.

Pharmacy team members explained they tried to check medicine expiry dates every 12 weeks. Recently they had struggled to keep the checks up to date and felt this may be due to having fewer team members than normal. They did not keep records of the checks they had completed. But they kept a record of items expiring each month. They highlighted any short-dated items with a sticker on the pack up to six months in advance of its expiry. And removed these items during their month of expiry. After a search of shelves, the inspector did not find any out-of-date medicines. The pharmacy responded to drug alerts and recalls. And, any affected stock found was quarantined for destruction or return to the wholesaler. It recorded any action taken. And, records included details of any affected products removed. The pharmacy team kept the contents of the pharmacy fridge tidy and well organised. They monitored minimum and maximum temperatures in the fridge every day. And they recorded their findings. The temperature records seen were within acceptable limits.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the necessary equipment available, which it properly maintains. And it manages and uses the equipment in ways that protect people's confidentiality.

Inspector's evidence

The pharmacy had the equipment it needed to provide the services offered. The resources available included the British National Formulary (BNF), the BNF for Children, various pharmacy reference texts and use of the internet. The pharmacy had a set of clean, well maintained measures available for medicines preparation. And it had various items of diagnostic equipment available for use with the online GP service. MedicSpot were responsible for the equipment's maintenance and providing cleaning materials for the equipment. The pharmacy positioned computer terminals away from public view. They were password protected. It stored medicines waiting to be collected in the dispensary, also away from public view. The pharmacy had a dispensary fridge that was in good working order. Pharmacy team members used it to store medicines only. They restricted access to all equipment. They stored all items securely.

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.