General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: D & K Chemist, 380 Moston Lane, Moston, MANCHESTER, Lancashire, M40 9LX

Pharmacy reference: 1033581

Type of pharmacy: Community

Date of inspection: 17/04/2019

Pharmacy context

This is a community pharmacy located on a traditional shopping parade on a busy main road in an urban residential area. The pharmacy changed ownership around June 2018. It primarily supplies NHS prescription medicines, with some people receiving them in weekly compliance packs, which are an aid to taking medicines safely. It also provides a home delivery service, and other NHS services such as Medicine Use Reviews (MURs) and a minor ailments scheme.

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 has written procedures to help make sure the team works safely. But not everyone in the pharmacy team has read them, which could introduce unnecessary risks. The pharmacy team members discuss their mistakes, but they rarely record them, so it is unclear how effectively they learn from them. They understand the importance of protecting people's information. But they do not complete formal training, so they may not be fully aware of the risks. The team members recognise their role in protecting vulnerable people. But some of them have not participated in relevant training, which may mean they are not sure how to identify vulnerable people or deal with safeguarding concerns.

Inspector's evidence

The pharmacy had written procedures issued in June 2017 that covered the responsible pharmacist (RP) regulations and controlled drugs (CDs). However, most staff had not signed to declare they had read the procedures, and the procedures had no review date. Similarly, most staff had not read the pharmacy's written procedures covering the general practice of dispensing medicines issued in June 2017 or November 2017. And, all the staff involved in compliance pack dispensing had not signed to declare they had read the corresponding written procedures.

In addition, there were no written procedures on how the pharmacy ordered patient's prescriptions, or for dispensing high-risk medicines such as anti-coagulants, lithium, methotrexate, lithium, valproate or fentanyl. So, patients receiving these medicines may not always be appropriately screened or counselled.

The manager, who was also one of the regular pharmacists, said that the pharmacy team immediately discussed mistakes they made while dispensing medicines. And, they took steps to address each mistake in isolation. But, the paucity of records suggested they did not routinely record them. So, they were less likely to identify patterns or trends and mitigate risks in the dispensing process.

The 'dispensed by' and 'checked by' boxes on dispensing labels were inconsistently initialled on several randomly selected dispensed medicines. So, it was more difficult investigating and managing risk in relation to near miss or dispensing incidents, as well as reducing transparency around who was responsible for dispensing each medication.

The pharmacy team received positive feedback in the last patient satisfaction survey conducted in 2018. However, only some of the team had signed to declare they had read and understood the pharmacy's complaint handling procedures. And, there was no publicly displayed information about how patients could raise concerns. So, the pharmacy may not always get feedback that it could use to improve the services it provided.

The pharmacy had professional indemnity cover for the services they provided. Records for CD transactions and destructions, and the RP log were generally in order. There were a few occasions when the RP had not recorded when they ceased in the role, which is required by law and could lead to confusion.

The Superintendent and RP had briefly discussed the importance of protecting patient confidentiality

with the staff. However, many staff had not signed patient confidentiality agreements, or read the GDPR training material or data protection/IG policies. Also, there had been no data protection/IG review for at least a year. The team anecdotally intervened and involved the GP and carer when patients struggled to manage their medication, which typically happened when patients exhibited signs of confusion, memory loss.

The manager and superintendent were level 2 safeguarding accredited. Some of the pharmacy team said they had also participated in formal safeguarding training. However, many of the staff had not, and there was no formal procedure on how they should handle safeguarding concerns or list of local contacts who they should discuss concerns with. The manager explained the system for recording concerns, but the absence of procedures meant staff may not know where to record them.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough staff to provide its services and the team works well together. But, team members are not actively supported to complete ongoing training. And, they do not receive feedback through an appraisal process . This could mean that gaps in their skills and knowledge are not identified and supported.

Inspector's evidence

The staff present were; the owner/superintendent who was also one of the full-time regular pharmacists; RP/manager who was the other full-time regular pharmacist; one full-time dispenser; one full-time trainee dispenser. The other staff employed were; two dispensers; one trainee dispenser.

There were sufficient staff to comfortably manage the workload, reflected in the superintendent's comments that MDS medicines were routinely dispensed between one to three days before the patient required them, and repeat medicines were dispensed via the prescription ordering service around one or two days before the anticipated date patients needed them. Although around half of the prescriptions dispensed were presented personally by patients, there were no obvious or notable queues of them waiting for their medication to be dispensed. The consistent presence of two pharmacists and lunch-time closure meant work-load pressures were minimal.

The pharmacy team worked well both independently and collectively in providing services. One of the trainee dispensers, employed since the beginning of March 2019, had previously completed half of a qualification course around two years ago at another pharmacy, so had gained some skills and knowledge, but would have to re-start the course from the beginning. The superintendent said that he was in the process of enrolling the trainee on a course.

The other trainee dispenser, employed in this role at the pharmacy for around three or four years, had only enrolled on a qualification course around a year ago and only completed one module around October 2018. Their lack of progress had not been reviewed or addressed.

One of the dispenser's qualification, who was not present, was unclear. No documentation to support their accreditation was available. Neither the manager nor superintendent/owner had established their accreditation, and staff thought they had qualified around twenty years ago.

There was no structured appraisal process and training programme or equivalent for accredited staff. The superintendent/owner said that no official targets were set for the volume of services delivered.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises are suitable for the services provided, and it has a place where people can talk privately.

Inspector's evidence

The level of cleanliness was appropriate for the services provided. There was sufficient space in the dispensary to allow medicines to be dispensed safely for the scale of services provided. The consultation room offered the privacy necessary to enable confidential discussion, but had limited signposting e.g. it was not advertised in the front window.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy generally manages its services safely. The pharmacy team members offer some additional support to people on more complex medicines. But they do not always identify people who receive higher risk medicines. So, it may miss opportunities to provide people with the information they need to take their medicines safely. The pharmacy obtains its medicines from licensed suppliers, and it generally manages medicines safely. But it is unclear how often it checks medicine stock expiry dates. So, there is a risk that it could give out medicines when they have passed their 'use by' date.

Inspector's evidence

The pharmacy team provided services from 9am to 6pm Monday to Friday, closed one hour for lunch, and half-day on Saturdays, meaning patients could access services across most of the week.

The pharmacy kept schedules for ordering patient's repeat prescriptions seven days before it was anticipated they were due. It asked patients to confirm the repeat medications they required when they collected their medication at the pharmacy. However, an equivalent process did not exist for the significant number of patients who had their medication delivered. This could mean the pharmacy sometimes dispensed unnecessary medications.

The pharmacy team kept records of prescriptions they ordered for patients up to the point of prescription receipt only. So, they could struggle to resolve queries after patients had received their medication.

The pharmacy team had worked in consultation with GPs to establish whether it was safe to issue medication on either a weekly or monthly basis to compliance pack patients. However, the team did not make records to support why they decided to supply medications monthly to individual patients. So, it was unclear why it was safe to do so.

The pharmacy team used disposable compliance packs to dispense medicines for patients who needed extra support taking their medicines safely. However, a few randomly selected trays were not labelled with descriptions of each medicine. So, patients may become confused about their medicines. The superintendent said that staff usually included medicine identification details.

Overall, there was scope to better support patients taking high-risk medicines. The RP/manager said they had screened female patients prescribed valproate to identify those who were in the at risk group and, therefore, at risk from the teratogenic risks of valproate. The one identified patient was contacted to alert them to the risk.

However, the team had not asked if they had been advised about the Pregnancy Prevention Programme (PPP) or consulted their GP. The MHRA approved guidance booklet had not been provided to the patient, and the cards had not been given to any female patient, contrary to MHRA guidance, as neither were available.

The manager routinely screened patients who collected their anti-coagulants to make sure they had their INR regularly monitored, but did not keep corresponding records. They did not counsel them on their prescribed dose, or regularly remind them of potential side-effects or interactions. Patients who

had their anti-coagulants delivered were neither screened nor counselled.

Methotrexate patients were routinely counselled on their prescribed dose and folic acid, but not the potential side-effects or interactions. And, they were not screened for regular blood tests. Lithium patients were not screened for regular blood tests.

The pharmacy did not counsel patients on the safe use and disposal of fentanyl patches. So, there was a risk that patients did not how to use and dispose of them safely.The pharmacy team used baskets to avoid each patient's medicines becoming confused with others during the dispensing process. The pharmacy used a range of MHRA licensed pharmaceutical wholesalers to obtain its medicines.

The Superintendent said that the hardware required for compliance with the Falsified Medicines Directive (FMD) was installed. However, he was unsure if the corresponding software was also installed, and the pharmacy was not registered with the organisation responsible for establishing the UK medicines verification system to enable the FMD. So, the pharmacy's system for adhering to the FMD was not live.

The pharmacy team stored thermo-labile medicines in two refrigerators, but only consistently monitored and recorded the refrigeration storage temperatures for one. The Superintendent explained that the refrigerator not monitored had only been recently installed around two weeks ago. So, it was unclear whether these medicines had been stored at their correct temperature.

The team recalled medicine stock was last fully date-checked recently, with the previous occasion around April 2018. No records could not be located to verify the date-checking frequency, and no corresponding SOP existed. Several randomly selected stock medicines were not due to expire for a long time, except for one inhaler that expired at the end of December 2018, which the Superintendent said was rarely dispensed.

The pharmacy team used an alphabetical system to store and retrieve bags of dispensed medication and the related prescription. So, the team could efficiently retrieve patients' medicines and prescription when they came to collect their medication.

The pharmacy team consistently obtained patients'/recipients' signatures for medicines they delivered, meaning they provided a safe and secure service. Obsolete medicines were disposed of appropriately in pharmaceutical waste bins segregated away from medicines stock, which reduced the risk of medicines not fit for purpose being supplied to patients.

The pharmacy team took appropriate action when they received alerts/recalls for medicines suspected of not being fit for purpose. They also made records related to the action taken. So, the team made sure patients did not receive medicines that were potentially unsafe.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs to provide the services it offers.

Inspector's evidence

The pharmacy team kept the dispensary sink clean. They also had cold running water and an anti-bacterial hand-sanitiser at dispensary sink. However, they could only access running hot water via the WC.

The team had a range of clean measures. So, they could accurately measure and give patients their prescribed volume of medicine. The team had the latest paper version of the BNF version available for reference. However, no arrangements had been made for access to the cBNF. The Superintendent said that they would address this.

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.