General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Suburb Pharmacy, 390 Hollins Road, OLDHAM, Lancashire, OL8 3BE

Pharmacy reference: 1033759

Type of pharmacy: Community

Date of inspection: 06/01/2020

Pharmacy context

This pharmacy is located in a residential area which has a diverse community and some of the people are non-English speakers. The pharmacy dispenses NHS prescriptions and sells a range of over-the-counter medicines. It supplies a large number of medicines in multi-compartment compliance aid packs to help people take their medicines at the right time.

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 manages risks to make sure its services are safe and acts to improve patient safety. The team has written procedures on keeping people's private information safe and team members understand how they can help to protect the welfare of vulnerable people. The team keep the records required by law, but some details are missing, which could make it harder to understand what has happened if queries arise.

Inspector's evidence

The pharmacy had up-to-date standard operating procedures (SOPs) for most of the services provided, with signatures showing that members of the pharmacy team had read and accepted them. Roles and responsibilities were set out in SOPs and the pharmacy team members were performing duties which were in line with their role. They were wearing uniforms but nothing to indicate their role, so this might not be clear to members of the public. There were two notices on display showing different names of the responsible pharmacist (RP), neither of whom was the RP who was actually on duty. This was not in line with RP regulations and might cause confusion in the event of a problem or query. The RP removed the two incorrect notices and displayed a notice with her details on it when this was pointed out.

A procedure was in place for analysis of patient safety incidents which included a root cause analysis. The team could not recall any recent dispensing errors but there was a reported error in 2018 when the wrong strength of Fostair inhaler had been supplied. As a result of this incident, these inhalers were stored in clear bags when dispensed to allow an extra check before being supplied. Clear plastic bags were also used for assembled CDs and insulin to allow an additional check at hand out . There was a near miss SOP. Near misses were reported and discussed with the pharmacy team. These were reviewed by the pharmacist superintendent (SI) who also completed the annual patient safety report. Shared learning was circulated within the company in a WhatsApp messenger group, which the SI, pharmacists and pharmacy technicians (PT) in the company were part of. Alert stickers were in front of look-alike and sound-alike drugs (LASAs) on the dispensary shelves so extra care would be taken when selecting these. For example, prednisolone and propranolol, allopurinol and atenolol, azithromycin and azathioprine.

There was a complaints policy and procedure but this was not displayed so people might not know how to raise a concern or give feedback. A customer satisfaction survey was carried out annually. The results of the most recent survey were available on www.NHS.uk website. Results indicated that areas of strength (100%) included staff overall, having somewhere available where you could speak without being overheard, clear and well organised layout and the comfort of the waiting area. An area identified which required improvement (1% dissatisfied) was 'having in stock the medicines/appliances you need'. The pharmacy's published response to this was 'Stock figures to be checked and amended more frequently'.

Insurance arrangements were in place. A current certificate of professional indemnity insurance was on display in the pharmacy. Private prescription records and the controlled drug (CD) register were appropriately maintained but records of CD running balances were not regularly audited. The last recorded balance checks of most CDs was completed in September 2019. Two CD balances were

checked and found to be correct during the inspection. The RP record did not show the time the RP ceased their activities each day. This was not in line with RP regulations and means the record might not be sufficiently accurate in the event of a problem or query.

The pharmacy was registered with the Information Commissioner's Office (ICO). Members of the pharmacy team had read and signed confidentiality, data protection and information governance (IG) policies and these were available in the IG file. Confidential waste was collected in a designated place and then shredded. The RP correctly described the difference between confidential and general waste. Assembled prescriptions awaiting collection were not visible from the medicines counter. A statement that the pharmacy complied with the General Data Protection Regulation and the NHS Code of Confidentiality was given in the practice leaflet, but these were not on display. 'How we look after and keep the information about you secure' leaflets and a privacy statement were available but not on display, so people might not know they were available.

The pharmacists and PT had completed the Centre for Pharmacy Postgraduate Education (CPPE) level 2 training on safeguarding. There was guidance on child protection and a member of the team said she would voice any concerns regarding children or vulnerable adults to the pharmacist working at the time and pointed out the contact details of who to report safeguarding concerns to in the local area, which was on a notice on display in the dispensary. There was nothing on display to indicate the pharmacy had a chaperone policy, so people might not realise this was an option. Members of the team confirmed that they would suggest a chaperone if they felt this was appropriate. For example, when measuring a patient for support stockings. Members of the pharmacy team had completed Dementia Friends training, so had a better understanding of patients living with this condition.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy team members have the right qualifications for the jobs they do, and they get some ongoing training to help them keep up to date. The team members work well together, and they are comfortable providing feedback to their managers.

Inspector's evidence

There was a locum pharmacist, a PT, two NVQ2 qualified dispensers and a delivery driver on duty at the time of the inspection. The staffing level was adequate for the volume of work during the inspection and the team were observed working collaboratively with each other and the patients. Planned absences were organised so that not more than one person was away at a time. Absences were covered by re-arranging the staff rota or transferring staff from a neighbouring branch. There were two regular pharmacists who shared the management duties. Neither were present at the inspection. But the locum pharmacist was familiar with the pharmacy, having completed her pre-registration training there.

Members of the pharmacy team carrying out services had completed appropriate training. A folder of certificates showing completed training for members of staff was available. Training had been completed on sepsis, LASAs and oral health. Members of the team were given regular protected training time when on training courses. Other members of the team completed training when it was quiet. The PT was enrolled on an accuracy checking course on CPPE. One of the dispensers was working through a training course on healthy living and over the counter medicines, which was in addition to the accredited training she had received.

The SI visited the pharmacy most weeks to support the team. The pharmacy team were given formal appraisals where performance and development were discussed with the SI, although these were not conducted very often and there had not been any in the last two years. E-mails were received throughout the day from head office and these could be viewed on a screen next to the computer in the dispensary. Day-to-day issues were discussed as they arose. One of the dispensers said she discussed issues at hand-over with colleagues. Team members felt there was an open and honest culture in the pharmacy and said they would feel comfortable talking to one of the regular pharmacists or SI about any concerns they might have. They could make suggestions or criticisms informally. There was a whistleblowing policy and one of the team said she could contact head office if she did not want to discuss the concern with the pharmacists or SI. GPhC and Royal Pharmaceutical Society (RPS) guidance on raising concerns were available. The PT said she felt comfortable admitting her errors and felt that learning from mistakes was encouraged.

The RP said she felt empowered to exercise her professional judgement and could comply with her own professional and legal obligations. For example, refusing to sell a pharmacy medicine containing codeine, because she felt it was inappropriate. Numbers of Medicines Use Reviews (MUR) and flu vaccinations were monitored but there was no pressure on her to complete these.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises generally provide a professional environment for people to receive healthcare. The pharmacy has a private consultation room that enables it to provide members of the public with the opportunity to have confidential conversations.

Inspector's evidence

The pharmacy premises including the shop front and facia were reasonably clean and in an adequate state of repair. The retail area was free from obstructions, professional in appearance and had a waiting area with three chairs. There was am additional chair next to the medicine counter. The temperature and lighting were adequately controlled. Maintenance problems were reported to head office who would either contact the landlord or a company maintenance man, depending on the nature of the issue. There was some ongoing repairs being carried out on the roof.

Staff facilities were limited to a small kitchen area and a WC. There was a wash hand basin but it could not be accessed due to a large number of medicine waste bins, which were stored in that area. So, the dispensary sink was used for both hand washing and medicines preparation, which was not very hygienic. There was hot and cold running water at the dispensary sink and hand sanitizer gel was available.

The consultation room was uncluttered, clean and professional in appearance. The availability of the room was highlighted by a sign on the door. The pharmacy team used this room when carrying out the services and when customers needed a private area to talk.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's services are accessible to most people and they are generally well managed, so people receive appropriate care. The pharmacy sources, stores and supplies medicines safely. And it carries out some checks to ensure medicines are in good condition and suitable to supply.

Inspector's evidence

There was a step up to the front door of the pharmacy, but it was possible for customers to enter with prams and wheelchair users with assistance. There was a bell at the door and staff said they would always be ready to serve customers at the door if necessary. There was a hearing loop in the pharmacy. The two regular pharmacists were multilingual, speaking Urdu and Punjabi as well as English. Some customers were Eastern European and the team used Google translate if they did not speak English and had not brought an interpreter with them.

The flu vaccination service and delivery service were promoted but other services provided by the pharmacy were not advertised, so people might not know what was offered. The pharmacy team were clear what services were offered and where to signpost to a service not offered. A notice was on display in the dispensary containing relevant signposting information which could be used to inform patients of services and support available elsewhere. There was a range of healthcare leaflets and posters increasing awareness of bowel, breast and pancreatic cancer. Signposting and providing healthy living advice were not usually recorded. It was therefore difficult to monitor the effectiveness of the health promotional activities.

The pharmacy offered a repeat prescription ordering service for some patients, if their GP surgery allowed this. These patients indicated their requirements a month in advance when they collected their medication. Requirements were checked again at hand-out and any unwanted medicines were retained in the pharmacy and the prescription endorsed as not dispensed. This was to reduce stockpiling and medicine wastage. There was a home delivery service with associated audit trail. Each delivery was recorded, and a signature was obtained from the recipient. A note was left if nobody was available to receive the delivery and the medicine was returned to the pharmacy. The delivery driver described the delivery process which was in line with the SOP.

Space was quite limited in the dispensary and the benches were a little cluttered and some of the shelves untidy. However, the work flow was well organised into separate areas with a designated checking area. Different coloured baskets were used to improve the organisation in the dispensary and prevent prescriptions becoming mixed up. The baskets were stacked to make more bench space available. Dispensed by and checked by boxes were initialled on the medication labels to provide a dispensing audit trail. A robust audit trail was in place for supervised methadone which was assembled in advance to effectively manage work load and doses were stored securely in the CD cabinet.

Stickers were put on assembled prescription bags to indicate when a fridge line or CD was prescribed. 'Urgent' stickers were used to highlight when counselling was required and high-risk medicines such as warfarin, lithium and methotrexate were targeted for extra checks and counselling. INR levels were

requested but not usually recorded when dispensing warfarin prescriptions. The team were aware of the valproate pregnancy prevention programme. An audit had been carried out and one patient in the at-risk group had been identified, but the team had not managed to have a conversation with her yet about pregnancy prevention. The valproate information pack and care cards were available to ensure people in the at-risk group were given the appropriate information and counselling.

Four weekly multi-compartment compliance aid packs were often assembled from the first week's prescription which increased the risk of error, especially if any changes were made by the prescriber. Team members confirmed the packs were always checked again when the current prescription arrived but said they would review this practice. There was a partial audit trail for changes to medication, but it was not always clear who had confirmed these and the date the changes had been made, which could cause confusion in the event of a query. A dispensing audit trail was completed, and medicine descriptions were usually included on the packaging to enable identification of the individual medicines. The pharmacy team confirmed packaging leaflets were included at least once each month, so patients and their carers could easily access all the required information about their medicines. However, none were seen in the samples checked so this could not be verified. Disposable equipment was used. The team explained that when new people requested a compliance aid pack an assessment was made by the pharmacist as to the appropriateness of a pack. This was outlined in a SOP, but team members could not locate a SOP for the assembly and checking of multi-compartment compliance aid packs, so may not be clear of this process. Subsequent to the inspection the SI confirmed that a SOP was available in electronic version which he had now printed off for the pharmacy team to read and sign.

One of the dispensers explained what questions to ask when making a medicine sale and when to refer the patient to a pharmacist. She was clear which medicines could be sold in the presence and absence of a pharmacist and understood what action to take if she suspected a customer might be abusing medicines such as a codeine containing product. CDs were stored in a CD cabinet which was securely fixed to the wall. Date expired, and patient returned CDs were segregated and stored securely. Patient returned CDs were destroyed using denaturing kits. Pharmacy medicines were stored behind the medicine counter so that sales could be controlled.

Recognised licensed wholesalers were used to obtain medicines and appropriate records were usually maintained for medicines ordered from 'Specials'. No extemporaneous dispensing was carried out. The pharmacy was not compliant with the Falsified Medicines Directive (FMD) and the team were not scanning to verify or decommission medicines. They had the software and hardware needed to comply, and the team had carried out some training, but had found that the system wasn't working properly, so they were waiting for advice from head office.

Medicines were stored in their original containers at an appropriate temperature. Date checking was carried out and documented. Short dated stock was highlighted. Dates had not been added to two opened bottles of Oramorph solution and Sytron which once opened had limited stability, so it was not possible to know if they were fit to use. The RP said she would not use these, and they would be destroyed. Expired medicines were segregated and placed in designated bins.

Alerts and recalls were received via e-mail messages from head office and from NHS England. These were read and acted on by a member of the pharmacy team but action taken was not usually recorded so the team would not easily be able to respond to queries and provide assurance that the appropriate action had been taken. The team confirmed they would start to record their actions.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

Members of the pharmacy team have the equipment and facilities they need for the services they provide. They maintain the equipment so that it is safe and use it in a way that protects privacy.

Inspector's evidence

Current versions of the British National Formulary (BNF) and BNF for children were available and the pharmacist could access the internet for the most up-to-date information. There were two clean medical fridges. The minimum and maximum temperatures were being recorded regularly and had been within range throughout the month. All electrical equipment appeared to be in good working order and had been PAT tested.

There was a selection of clean glass liquid measures with British standard and crown marks. Separate measures were marked and used for methadone solution. The pharmacy had a range of equipment for counting loose tablets and capsules. Disposable gloves were available for counting cytotoxic drugs, although these were usually obtained in foils strips which meant less handling was necessary. Medicine containers were appropriately capped to prevent contamination.

Computer screens were positioned so that they weren't visible from the public areas of the pharmacy. Patient medication records (PMRs) were password protected. Individual electronic prescriptions service (EPS) smart cards were used appropriately. Cordless phones were available in the pharmacy, so staff could move to a private area if the phone call warranted 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.