General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Broadway Pharmacy, 331 Garstang Road, Fulwood, PRESTON, Lancashire, PR2 9UP

Pharmacy reference: 1033817

Type of pharmacy: Community

Date of inspection: 28/08/2019

Pharmacy context

This is a community pharmacy located on a major road through the residential area of Fulwood, Preston. The pharmacy dispenses NHS prescriptions, private prescriptions and sells over-the-counter medicines. It also provides a range of services including seasonal flu vaccinations, a travel clinic, a minor ailment service and emergency hormonal contraception. A number of people receive their medicines in multi-compartment compliance aids.

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 team follows written procedures, and this helps to maintain the safety and effectiveness of the pharmacy's services. They are given training so that they know how to keep private information safe. Members of the team record things that go wrong and discuss them to help identify learning and reduce the chances of similar mistakes happening again. The pharmacy generally keeps the records it needs to by law.

Inspector's evidence

There was a set of standard operating procedures (SOPs) which were reviewed in January 2019. Some of the pharmacy team had signed to say they had read and accepted the SOPs. But a number of the staff had yet to do this since they had been reviewed. So some members of the pharmacy team may not be fully aware of current procedures or where their responsibility lies.

Dispensing errors were recorded electronically. The most recent error involved the incorrect dosage on a dispensing label for valproate. The pharmacist had investigated the error and found it had been self-checked by another pharmacist. The pharmacy team were informed, and the pharmacist said he would endeavour not to check self-dispensed medicines. Near miss errors were recorded on an electronic system. The pharmacist said he would print out the weekly review and discuss it with the staff each week on a Monday morning. The pharmacist would also highlight mistakes to staff at the point of accuracy check and ask them to rectify their own errors. He gave examples of action taken to help prevent similar mistakes, which included moving Lorazepam away from Lormetazepam and using alert stickers in their dispensary locations. But they did not keep records of the action taken, which would help the pharmacy team to demonstrate the learning identified from the process.

Roles and responsibilities of the pharmacy team were described in individual SOPs. The pharmacy student was able to describe what his 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 pharmacy had a complaints procedure. This was described in the practice leaflet, which advised people they could give feedback to members of the pharmacy team. Complaints were recorded to be followed up by the superintendent (SI). A current certificate of professional indemnity insurance was on display in the pharmacy.

The responsible pharmacist (RP) notice was displayed prominently. But it was for the incorrect pharmacist who had not been present for the last two days. This was promptly amended by the pharmacy team. The correct pharmacist was signed in to the RP register. But the RP routinely did not record the end of their tenure. So the pharmacy may not always be able to demonstrate which pharmacist was present at a specific point in time.

Controlled drugs (CDs) registers were maintained with running balances recorded. The balance of MST 10mg MR tablets, Oxycodone 10mg MR tablets and Matrifen 12mcg Patches were checked and found to be accurate. A register to record patient returned CDs was available. Records for private prescriptions, emergency supplies and unlicensed specials appeared to be in order. The pharmacy regularly supplied medicines against signed orders to GP surgeries and healthcare providers in the local area. But the pharmacy did not have a wholesale dealers licence, so it was unclear whether there was

any legal provision to make these supplies. Further guidance should be sought from MHRA.

An information governance (IG) policy was available. The pharmacy team said they had read the policy and signed a confidentiality agreement. When questioned, the counter assistant said confidential waste was segregated into a separate bin. This was taken away by a waste carrier. But there was no information displayed about the company's privacy notice. So the public may not be fully informed as is legally required.

Safeguarding procedures were available and had been read by the pharmacy team. Registered staff had completed level 2 safeguarding training. Contact details of the local safeguarding board were available. The technician 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 properly trained for the jobs they do. Members of the pharmacy team complete some additional training to help them keep their knowledge up to date. They get feedback from their manager to help them improve.

Inspector's evidence

The pharmacy team included two pharmacists – one of whom was the SI, a pre-registration pharmacist, an accuracy checking technician (ACT), two pharmacy technicians, an accuracy checking dispenser, five dispensers, a pharmacy student, three medicine counter assistants (MCA), and four drivers. All members of the team had completed the necessary training for their roles. The normal staffing level was two pharmacists, three to four staff in the dispensary, one to two staff in the upstairs dispensary, and four staff on the counter and retail area. The normal staffing level would usually include two accuracy checkers. The volume of work appeared to be managed. Staffing levels were maintained by part-time staff and a staggered holiday system.

The company provided the pharmacy team with some additional training, for example learning topics on the e-learning package ‘virtual outcomes.’ 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.

The MCA 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 SI. The pharmacy student said he felt he was given a good level of support from the pharmacy team and felt able to ask for further help.

Appraisals were conducted annually by the pharmacy management. A technician said she felt that the appraisal process was a good chance to have a private conversation about her work. Staff were aware of the whistleblowing policy and said that they would be comfortable reporting any concerns to their manager or SI. There were no service based targets set by the company.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are suitable for the services provided. But some basic improvements could be made to help control access to some areas of the pharmacy. Consultation rooms are available to enable private conversations.

Inspector's evidence

The pharmacy was clean and tidy, and appeared adequately maintained. The size of the dispensary was limited for the amount of work being completed. The staff said they would manage the workload to prevent overcrowding. 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 the position of the counter. The temperature was controlled by the use of electric heaters. Lighting was sufficient. The staff had access to a kitchenette and WC facilities.

Two consultation rooms were available with access restricted by use of a lock. Their spaces were clutter free with a computer, desk, seating, and adequate lighting. One of the rooms also had a wash basin. The patient entrance to the consultation room was clearly signposted.

The premises included an area which was sub-let to a hairdresser. This was a separate company based upstairs, with access via a staircase in the retail area. They did not have their own set of keys and were only able to access the premises during the opening hours of the pharmacy. The hairdresser staff had use of the kitchenette area – which had a connecting door to the upstairs dispensary. This door was left unlocked throughout the inspection. So there is an increased risk of unauthorised access to prohibited areas.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's services are easy to access. And it manages and provides them safely. It gets its medicines from appropriate sources, stores them appropriately and carries out some checks to help make sure that they are in good condition. But the pharmacy team does not always identify people who receive higher-risk medicines. So it 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 a single door and was suitable for wheelchair users. There was also wheelchair access to the downstairs consultation room. A service panel and pharmacy practice leaflets gave information about the services offered. There was also information available on the pharmacy's website. The 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 at the entrance of the pharmacy and included details of the pharmacy bank holiday provision rota. A range of leaflets provided information about various healthcare topics.

The pharmacy had a delivery service. Deliveries were segregated after their accuracy check and a delivery slip was used to obtain signatures from the recipient to confirm delivery. 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 separate signature was obtained to confirm receipt.

Dispensed by and checked by boxes were initialled on dispensing labels to provide an audit trail. Dispensing baskets were used for segregating individual patients' prescriptions to avoid items being mixed up and 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. When medicines were to be checked by an accuracy checker, the pharmacist would perform a clinical check of the relevant prescriptions and then signed the prescription form to indicate this had been completed. When this had been done an accuracy checker was able to perform the final accuracy check.

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.

Prescriptions for schedule 3 CDs were segregated and assembled at the time of collection. The pharmacist said the legal check of the prescription would also be completed. But there were no processes in place to check prescription validity for schedule 4 CD prescriptions. So there is 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. The pharmacy had run out of educational material to hand out when the medicines were supplied. So people may not

always be provided with important information. The pharmacist said he had completed an audit and had spoken to the patients who were at risk and made them aware of the pregnancy prevention programme. This was recorded on their PMR.

Some medicines were dispensed in multi-compartment 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 a dispensing check audit trail. Patient information leaflets (PILs) and medicine descriptions were not routinely supplied. So people may not be able to identify the individual medicines or have all of the information they need to take the medicines safely.

The pharmacy offered blistered medication to care homes. A re-order sheet was provided to the pharmacy and it contained details about the medicines required, medicine changes and any handover notes for the pharmacy. When prescriptions were received from the GP surgery they would be compared to the re-order sheet to confirm all of the requested medicines were received back. Any queries were provided to the care home to be chased up. Some medicines were dispensed into disposable compliance aids and a dispensing and checking signature was written onto the dispensing label.

The pharmacy provided a travel vaccine clinic, including the provision of the yellow fever vaccine. The pharmacist had completed the required face to face and online based training. Provision of vaccines was via a patient group direction (PGD) which included an inclusion and exclusion criteria. Records of assessment were used associated with the PGD and assessed suitability for supply. PGDs were available and current for the relevant pharmacists providing the service. The pharmacy was a registered site for the administration of yellow fever vaccines.

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 monthly basis. There were no records kept by staff to confirm what had been checked. So there is a risk that some stock may be overlooked. Short dated stock was highlighted using a sticker and liquid medication had the date of opening written on. A spot check of some medicines did not find any expired stock.

Controlled drugs were stored appropriately in the CD cabinet, with clear segregation between current stock, patient returns and out of date stock. There were clean medicines fridges, each with a thermometer. The minimum and maximum temperatures were being recorded. One of the fridges had been routinely exceeding the usual range of 2 to 8C. This fridge had been replaced and temperatures now appeared to be in range. Patient returned medication was disposed of in designated bins located away from the dispensary. Drug alerts were received by email and alerts were actioned electronically before being printed and filed. Alerts were highlighted to staff.

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, all electrical equipment had been PAT tested in February 2019. There was a selection of liquid measures with British Standard and Crown marks. 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.