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: 22/11/2022

Pharmacy context

This is a community pharmacy situated on a major road between the M55 motorway and Preston city centre. The pharmacy dispenses NHS prescriptions and sells over-the-counter medicines. It also provides a range of other services including seasonal flu vaccinations, and travel vaccinations. And it dispenses private prescriptions, including some issued by a private clinic that specialises in ADHD. The pharmacy supplies medicines in multi-compartment compliance aids for some people to help them take the medicines at the right time.

Overall inspection outcome

✔ **Standards met**

Required Action: None

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 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, which helps to maintain the safety and effectiveness of the pharmacy's services. 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 and discuss them to help identify learning and reduce the chances of similar mistakes happening again.

Inspector's evidence

There was a set of electronic standard operating procedures (SOPs). Training records were kept showing when members of the pharmacy team had read and accepted the SOPs. After reading the SOP the team member had to answer questions to check their understanding of the procedures before the training record could be completed.

The pharmacy dispensed private prescriptions issued by a clinic which specialised in treating attention-deficit hyperactivity disorder (ADHD). The clinic was registered with the CQC. Consultations were provided remotely by UK registered doctors and nurses. An SOP was available for this service. But the pharmacy did not have a written risk-assessment for the service, so it was not able to demonstrate whether the associated risks had been properly considered.

Near miss dispensing incidents were recorded on a paper log. The pharmacist said she would highlight mistakes to staff at the point of accuracy check and ask them to rectify their own errors. This included discussing why the error may have occurred and seeking to identify any learning points, such as checking the team member's understanding of the medicines. Records were kept of dispensing errors and any actions the team had taken in response to them.

Roles and responsibilities of the pharmacy team were described in individual SOPs. A dispenser was able to explain what her responsibilities were and was clear about the tasks which could or could not be conducted during the absence of a pharmacist. The responsible pharmacist (RP) had their notice displayed prominently. The pharmacy had a complaints procedure which was explained in the practice leaflet. Any complaints would be recorded and followed up by the SI. A current certificate of professional indemnity insurance was on display.

Records for the RP, private prescriptions and unlicensed specials appeared to be in order. Controlled drugs (CDs) registers were maintained with running balances recorded and checked weekly. Two random balances were checked, and both found to be accurate. Patient returned CDs were recorded in a separate register.

An information governance (IG) policy was available. The pharmacy team had completed IG training and each member of the team had signed a confidentiality agreement. Confidential waste was destroyed using a shredder. The pharmacy's website displayed details about how the pharmacy handled and stored people's information.

Safeguarding procedures were available and had been read by members of the pharmacy team. The pharmacist said she had completed level 2 safeguarding training. Contact details for the local

safeguarding board were on display. A dispenser said she would raise any concerns about a person's safety with 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.

Inspector's evidence

The pharmacy team included three pharmacists, one of whom was the superintendent (SI), three pharmacy technicians, a trainee pharmacy technician, five dispensers, one of whom was in training, and ten medicine counter assistants (MCA). All members of the pharmacy team were appropriately trained or on accredited training programmes. The normal staffing level was two pharmacists with five assistants in the upstairs dispensary and four assistants covering the medicines counter and retail area. The volume of work appeared to be well managed. Staffing levels were maintained by part-time staff and a staggered holiday system.

Members of the pharmacy team completed some additional training, for example they had recently completed a training pack about fire safety and sepsis awareness. Training records were kept showing what training had been completed. But further training was not provided in a structured or consistent manner. So learning needs may not always be fully addressed.

An MCA was seen to sell a pharmacy only medicine using the WWHAM questioning technique to check it was suitable. Team members said they would refer people to the pharmacist when necessary, for example, if a person was taking a number of prescribed medicines. The pharmacist said she felt able to exercise her professional judgement and this was respected by the SI and other members of the pharmacy team. Members of the team said they felt a good level of support from the management team and pharmacists. They were seen to be working well with each other and assisting with any queries which arose.

Appraisals were conducted annually by the management team and pharmacy manager. Members of the pharmacy team had recently held a meeting to discuss the ongoing work and any errors or complaints which had occurred. A communications diary was used to record important information so that it could be shared with team members who were not present. Members of the team were aware of the whistleblowing policy and said that they would be comfortable reporting any concerns to the SI. There were no professional based targets in place.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are suitable for the services provided. Consultation rooms are available to enable private conversations.

Inspector's evidence

This was a purpose-built pharmacy which had been refitted in the last few years. The retail area was spacious and had been equipped with 3 large consultation rooms. The rooms were clean and were suitable for the services being provided. The dispensary was located upstairs, and its size was sufficient for the workload. The temperature was controlled by the use of air conditioning units. Lighting was sufficient. Members of the team had access to a kitchenette and WC facilities.

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 recognised sources, stores them appropriately and carries out regular checks to help make sure that they are in good condition. But the pharmacy team are not routinely informed about when they are handing out higher-risk medicines. So they might not always be able to 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 consultation rooms. TV screens and leaflets provided information about the services offered, and there was information also available on the website. Pharmacy team members were able to list and explain the services provided by the pharmacy.

The pharmacy had a delivery service. Deliveries were electronically recorded, and signatures were obtained 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.

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. The baskets were colour coded to help prioritise dispensing.

The pharmacy utilised a patient medication record (PMR) system which had in-built accuracy checking software using barcode technology. The pharmacist had to clinically review each prescription before the team was able to produce a picking list. Medicines were selected according to the picking list and placed into a dispensing basket. Each medicine was scanned one at a time to produce a dispensing label. The software would highlight if the medication was not what was expected. Some medicines required an accuracy check by a pharmacist, such as when there had been a dose instruction change, a CD, or a medicine which had been re-packaged from its original pack. The pharmacy relied upon the PMR's developers to ensure the accuracy checking software was working correctly. And it had not implemented its own quality assurance system to actively monitor for potential errors, other than to rely on reactive feedback once an error had been identified. This may limit the team to demonstrate how accurately the system was working.

Dispensed medicines awaiting collection were kept on a shelf using an alphanumerical retrieval system. An electronic handheld device was used to record the location of the bags of dispensed medicines, and if there were any items that needed to be added, such as CDs or fridge lines. The handheld device would also recognise if the prescription had expired. Team members were seen to confirm the patient's name and address when medicines were handed out.

The pharmacist was able to add counselling notes or a 'refer to pharmacist' flag on the handheld device for team members to action. But they did not always do this for high-risk medicines (such as warfarin, lithium and methotrexate). So there may be missed opportunities to counsel people about their medicines and to check the latest blood test results. 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 the pharmacy did not currently have any patients who met the risk criteria.

Some medicines were dispensed in multi-compartment compliance aids. Before a person was started on a compliance aid the pharmacy asked a few questions to check their suitability, but this was not recorded. A record sheet was kept for each patient, containing details about 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 medication descriptions and a dispensing check audit trail. Patient information leaflets (PILs) were routinely supplied.

For medicines dispensed on behalf of the private ADHD clinic, the pharmacist had access to the clinic's electronic prescribing platform and consultation notes to inform their clinical check. A prescribing policy and formulary had been supplied by the clinic, which listed a limited number of medicines. The pharmacist gave an example of querying a prescription which had a titrating dose for a child, because he was unclear about the suitability of the timescale. He had accessed the clinical notes and so had been able to identify the reason for the prescribing and confirm it was suitable. All medicines for patients of the clinic were sent by Royal Mail Special Delivery service which had tracking capabilities and required a signature upon delivery.

Medicines were obtained from licensed wholesalers, and any unlicensed medicines were sourced from a specials manufacturer. Stock was date checked at least once every 3 months. A date checking matrix was signed by staff as a record of what had been checked, and shelving was cleaned as part of the process. Short-dated stock was highlighted using a sticker and liquid medication had the date of opening written on. 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. There were clean medicines fridges, each equipped with a thermometer. The minimum and maximum temperatures were being recorded daily and records were kept.

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

Members of the pharmacy team 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. 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.

Computers were password protected and were not visible to the public. A cordless phone was available in the pharmacy which allowed the staff to 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.