General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: A.S. Facer (Longton) Ltd., 66 Liverpool Road, Longton, PRESTON, Lancashire, PR4 5PB

Pharmacy reference: 1033830

Type of pharmacy: Community

Date of inspection: 03/12/2019

Pharmacy context

This is a community pharmacy located on a high-street. It is situated in the village of Longton, south-west of Preston city centre. 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 minor ailment service and emergency hormonal contraception. A number of people receive their medicines in multi-compartment compliance aids. The pharmacy had changed ownership about 3 months ago.

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. 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. But they do not always record things that go wrong, so they may miss some learning opportunities.

Inspector's evidence

There was a set of standard operating procedures (SOPs) available which had been written by the previous owners. An updated copy of the SOPs was available, but these had yet to be read by the pharmacy team. So members of the team may not know what is expected of them under the new ownership.

Dispensing errors were electronically recorded. A recent error involved the supply of the wrong strength of trimethoprim tablets. The pharmacist investigated the error and found it had been put in the wrong place in the dispensing robot. Action had been taken to prevent a similar mistake by removing all strengths of trimethoprim from the robot and replacing them back in their correct location. Paper logs were available to record near miss incidents, but the process had yet to be implemented. The pharmacist said historically there was little evidence of any action taken following near miss errors. She said until the new process was in place, she would speak to members of the pharmacy team and discuss any incidents which occurred.

Roles and responsibilities of the pharmacy team were described in individual SOPs. The trainee dispenser was able to explain what her responsibilities were. But she was unclear about the tasks which could or could not be conducted during the absence of a pharmacist. The superintendent (SI) said he would retrain her in the new SOPs to ensure she fully understands the requirements. The pharmacy had a complaints procedure. This was described in the practice leaflet and it advised people they could give feedback to members of the pharmacy team. Any complaints were recorded to be followed up by the pharmacist or head office. A current certificate of professional indemnity insurance was on display.

The responsible pharmacist (RP) had their notice displayed prominently and was signed in to the RP register. But the RP records did not always include the times the RPs ended their tenure. So the pharmacy may not be able to demonstrate who the RP was at a specific point in time. Controlled drugs (CDs) registers were maintained with running balances recorded. Two random balances were checked, and both found to be accurate. Patient returned CDs were recorded in a separate register. Records for private prescriptions, emergency supplies and unlicensed specials appeared to be in order.

An information governance (IG) policy was available. The pharmacy team had completed GDPR training and each member had signed a confidentiality agreement. When questioned, a pharmacy technician was able to describe how confidential waste was segregated to be removed by a waste carrier. A privacy notice was on display about how the pharmacy handled and stored people's information.

Safeguarding procedures were available and they contained the numbers for the local safeguarding board. Members of the pharmacy team had completed in-house training and registered members of the team had completed level 2 safeguarding training. A pharmacy 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 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 a pharmacist – who was the SI, three pharmacy technicians – one of whom was trained to accuracy check, two dispensing assistants – one of whom was in training, and four medicine counter assistants (MCA). Members of the pharmacy team were appropriately trained or on accredited training programmes. The normal staffing level was a pharmacist, four staff in the dispensary and two staff on the counter. At the time of inspection, the SI and a locum pharmacist was present. The volume of work appeared to be managed. Staffing levels were maintained by part-time staff and a staggered holiday system. Relief staff from other branches could be requested if necessary.

Members of the pharmacy team completed some additional training, for example they had recently completed a training pack about Children’s oral health. But further training was not provided in a structured or consistent manner. So learning needs may not always be fully addressed.

The trainee dispenser gave examples of how she would sell a pharmacy only medicine using the WWHAM questioning technique, refuse co-codamol sales she felt were inappropriate and refer people to the pharmacist if needed. The responsible pharmacist said she regularly worked alongside the SI and she felt her professional judgement was respected. The pharmacy team said they felt a good level of support following the change in ownership. They routinely discussed new ways of working and felt able to ask for further help if they needed it. Staff had yet to receive appraisals, so development needs may not always be identified. Staff were aware of the whistleblowing policy and said that they would be comfortable reporting any concerns to the head office. The pharmacy set targets for MURs, NMS and flu vaccinations. The locum pharmacist said she did not feel under pressure to achieve these.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are suitable for the services provided. A consultation room is available to enable private conversations.

Inspector's evidence

The pharmacy was clean and tidy, and appeared adequately maintained. The size of the dispensary was sufficient for the workload. A sink was available within the dispensary. The temperature was controlled by the use of air conditioning units. 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. They were clutter free with a computer, desk, seating, adequate lighting, and a wash basin. The patient entrance to the consultation room was clearly signposted and indicated if the room was engaged or available.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's services are easy to access, and they are generally well managed. But the pharmacy team does not always know when people are receiving higher-risk medicines. So it might not always check that the medicines are still suitable, or give people advice about taking them. The pharmacy team carries out some checks to make sure medicines are in good condition. But it does not always keep records, so it can't show that the checks have been done properly.

Inspector's evidence

Access to the pharmacy was level and was suitable for wheelchair users. There was also wheelchair access to the consultation rooms. Information about the pharmacy's services and opening hours were on display. Pharmacy staff were able to list and explain the services provided by the pharmacy. Leaflets provided information about various healthcare topics.

The pharmacy had a delivery service. Deliveries were segregated after their accuracy check and a delivery sheet 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.

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. Owing slips were in use to provide an audit trail if the full quantity could not be immediately supplied. Dispensed medicines awaiting collection were kept 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.

The pharmacist said prescriptions containing schedule 3 and 4 CDs were highlighted so that staff could check prescription validity at the time of supply. High-risk medicines (such as warfarin, lithium and methotrexate) were not routinely highlighted. So the pharmacy team were not always aware when they were being handed out in order to check that the supply was suitable for the patient. 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 she would speak to any patients who were at risk to make sure they were aware of the pregnancy prevention programme, which would be recorded on their PMR. The pharmacy team said they were not aware of any current 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 would refer them to their GP to complete an assessment about their suitability. 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 information was 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. But compliance aids were not labelled with medication descriptions and patient information leaflets (PILs) 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 dispensed medicines for a number of patients who were residents of 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 medicines had been received back. Any queries were chased up with the GP surgery. A copy of the query sheet was provided to the care home upon delivery of the medicines. Medicines were dispensed into disposable compliance aids and a dispensing and checking signature was written onto the seal.

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 checks of medicines. The pharmacy team said stock had recently been date checked prior to the change in ownership. But there was no process in place to routinely check the expiry date of medicines. So there is a risk some medicines may be overlooked. A spot check of medicines did not find out of date stock. The SI said he would implement a new expiry date checking procedure following the inspection. Liquid medication had the date of opening written on.

Controlled drugs were stored appropriately in the CD cabinets, 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 with a thermometer. One of the fridges contained a temperature recording device, but it was not routinely checked by staff. And there were gaps in the temperature records for the second fridge. So the pharmacy could not demonstrate that the temperatures had remained within the required range. Fridge temperatures remained between 2 and 8 Celsius during the inspection. Patient returned medication was disposed of in designated bins located away from the dispensary. Drug alerts were received by email from the MHRA. The pharmacist said she would check for any affected stock. But there were no records kept so the pharmacy was not able to show whether appropriate action had been taken.

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 were no stickers attached to indicate they had been PAT tested. 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. The pharmacy used a robot to help with the selection of medicines during dispensing. The SI said he knew how to raise a maintenance query with the manufacturer.

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.