General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Ribbleton Pharmacy, 182 Ribbleton Avenue, PRESTON, Lancashire, PR2 6QN

Pharmacy reference: 1033850

Type of pharmacy: Community

Date of inspection: 30/12/2019

Pharmacy context

This is a community pharmacy situated in the residential area of Ribbleton, east 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. 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	1.2	Good practice	Members of the pharmacy team record things that go wrong and discuss them to help identify learning and reduce the chances of similar mistakes happening again.
		1.7	Good practice	Members of the pharmacy team are given training so that they know how to keep private information safe.
2. Staff	Good practice	2.2	Good practice	Members of the pharmacy team complete regular training to help them keep their knowledge up to date.
		2.4	Good practice	Members of the pharmacy team get regular feedback from their manager and routinely discuss their work to help them improve.
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. 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 current set of standard operating procedures (SOPs), which had been issued in February 2019 and their stated date of review was February 2021. Members of the pharmacy team had signed to say they had read and accepted the SOPs. A daily checklist was completed to check compliance with a number of professional requirements, including fridge temperature records and display of the responsible pharmacist (RP) notice.

Dispensing errors were recorded electronically and submitted to the superintendent (SI). A recent error involved the incorrect assembly of a blister pack. The pharmacist had investigated the error and shared her findings with the pharmacy team. Members of the team had taken action to help reduce the risk of further errors by highlighting the prescription when there were uncommon dosage instructions. Near miss incidents were recorded electronically. The pharmacist explained that she would review the near miss records each month to identify underlying factors and discuss them with the pharmacy team. The pharmacist would also highlight mistakes to staff at the point of accuracy check and ask them to rectify their own errors. She gave examples of action taken to help prevent similar mistakes. For example, moving atenolol and allopurinol away from each other.

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. A notice in the retail area advised people they could discuss any concerns or feedback with the pharmacy team. Any complaints would be recorded and sent to the head office to be followed up. A current certificate of professional indemnity insurance was on display.

Records for the RP, private prescriptions, emergency supplies and unlicensed specials appeared to be in order. Controlled drugs (CDs) registers were maintained with running balances recorded and checked every two weeks. 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. Members of the pharmacy team had completed IG training and signed confidentiality agreements. When questioned, a dispenser was able to correctly describe how confidential waste was segregated to be destroyed using the on-site shredder. A privacy notice was on display and described how people's data was handled.

Safeguarding procedures were included in the SOPs. The pharmacy team had in-house safeguarding training and the pharmacist said she had completed level 2 safeguarding training. Contact details of the

local safeguarding board were available. A dispenser said she would initially report any concerns to the pharmacist on duty.

Principle 2 - Staffing ✔ Good practice

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 regular training to help them keep their knowledge up to date. Appraisals and team meetings are fully documented, showing a culture of openness, honesty and learning,

Inspector's evidence

The pharmacy team included a pharmacist manager, a pharmacy technician, and three dispensers. Members of the pharmacy team had completed the necessary training for their roles. The normal staffing level was a pharmacist and three other staff. On a Tuesday and a Friday, the normal staffing level was a pharmacist and four other staff. The volume of work appeared to be managed. A staggered holiday system was in place and part-time staff could provide extra cover if necessary.

The pharmacy provided the team with e-learning training packages. The training topics appeared relevant to the services provided and those completing the e-learning. Training records were kept showing that training was routinely completed by members of the team. Staff were allowed learning time to complete training.

A 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 pharmacist said she felt able to exercise her professional judgment and this was respected by the pharmacy team and the head office. A dispenser said she received a good level of support from the pharmacist and was able to ask for further help if she felt she needed it.

Appraisals were conducted by the pharmacist manager. A dispenser said she felt that the appraisal process was a good chance to receive feedback and she felt able to speak about any of her own concerns. The staff held weekly huddles about issues that had arisen, including when there were errors or complaints. A record was kept so that it could be shared with staff who were not present. Staff were aware of the whistleblowing policy and said that they would be comfortable reporting any concerns to the SI. There were targets for services such as MURs and NMS. The 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 and access to the dispensary was restricted by the position of the counter. Customers were not able to view any patient sensitive information due to the position of the dispensary. The temperature was controlled by the use of heating. Lighting was sufficient. The staff had access to a kitchenette and WC facilities.

A consultation room was available with access restricted by use of a lock. The space was clutter free with a laptop, desk, seating, and adequate lighting. The patient entrance to the consultation room was clearly signposted.

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 members of the pharmacy team do not always know 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 room. Various posters gave information about the services offered and information was also available on the website. Pharmacy 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 elsewhere using a signposting folder. The pharmacy opening hours were displayed and 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 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. CDs were recorded on a separate delivery sheet for individual patients and a signature was obtained to confirm receipt.

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 used to provide an audit trail if the full quantity could not be immediately supplied. Dispensed medicines awaiting collection were kept on a 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.

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 he 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.

Some medicines were dispensed in multi-compartment compliance aids. Before a person was started on a compliance aid, the pharmacist would complete an assessment or refer them to their GP to check their suitability. 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 included a dispensing check audit trail and patient information leaflets (PILs) were routinely supplied. But medicine

descriptions were not always provided. So people may not always be able to identify their medicines.

Medicines were obtained from licensed wholesalers, and any unlicensed medicines were 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 3-month rotating cycle. 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 cabinets, with clear segregation between current stock, patient returns and out of date stock. CD denaturing kits were available for use. There was a clean medicines fridge with a thermometer. The minimum and maximum temperature was being recorded daily and records showed they had been within the required range for the last 3 months. Patient returned medication was disposed of in designated bins located away from the dispensary. Drug alerts were received by email from the MHRA. Electronic records were kept about the alert received and the action 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. According to the stickers attached, electrical equipment had last been PAT tested in September 2019. 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 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. Substance misuse clients were directed to the use of the consultation room to provide 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.