General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Hollowood Chemists Ltd, 7 Ince Green Lane, Ince, WIGAN, Lancashire, WN2 2AR

Pharmacy reference: 1033954

Type of pharmacy: Community

Date of inspection: 07/05/2019

Pharmacy context

This is a community pharmacy near a major route into Wigan town centre. It is situated in the residential area of Ince, south-east of Wigan. 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 inside 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 to help make sure it provides services safely and effectively. But it does not record everything that goes wrong and does not always try to identify the things that may have caused mistakes. So it may miss some opportunities to improve. The pharmacy keeps the records it needs to by law. Staff are given training about the safe handling and storage of data, so that they know how to keep private information safe.

Inspector's evidence

There was a current set of standard operating procedures (SOPs) which were last issued in January 2018. The pharmacy team members had signed to say they had read and accepted the SOPs.

Dispensing errors were recorded electronically, which also submitted the report to the superintendent (SI). The most recent error involved the supply of Humalog insulin instead of Humalog Mix25 insulin. The pharmacist investigated the error and action was taken to help reduce the risk of further errors e.g. making the staff aware and placing an alert sticker on the fridge.

There were no records of near miss incidents. The pharmacist said he would highlight mistakes to staff at the point of accuracy check and staff were asked to rectify their own errors. He would review the error with the member of the pharmacy team to see if there was a contributing factor such as the location of stock. To help prevent errors being repeated the pharmacy team had segregated similar looking boxes of different strengths of lisinopril tablets.

The pharmacist had received shared learning from the PSNC about 'look alike, sound alike' drugs. The pharmacist discussed this information with the pharmacy team and they had placed alert stickers in the dispensary locations of these types of medicines, to help prevent errors.

Roles and responsibilities of the pharmacy team were described in individual SOPs. The dispenser was able to describe what her responsibilities were and was also clear about the tasks which could or could not be conducted during the absence of a pharmacist. Staff wore a standard uniform and the responsible pharmacist (RP) had their notice displayed.

The pharmacy had a complaints procedure and it was described in the practice leaflet. It advised customers how to make direct contact with the pharmacy. Complaints were recorded to be followed up by the pharmacy manager or head office.

A current certificate of professional indemnity insurance was on display in the pharmacy. 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 monthly. The balance of two random CDs 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 GDPR training

and had signed confidentiality agreements. Confidential waste was segregated by the pharmacy team, so it could be removed and destroyed by the head office. When questioned, the dispenser said she would not openly discuss confidential or patient information when there were other people waiting in the retail area. Information about how the company handled and stored data was on display in the retail area.

Safeguarding procedures were also available and had been read by staff. The pharmacist had a certificate to indicate he had completed level 2 safeguarding training. Contact details of the local safeguarding board were on display. The dispenser 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 learning modules to help them keep their knowledge up to date.

Inspector's evidence

The pharmacy team included a pharmacist manager, two dispensers and a trainee medicine counter assistant (MCA). The pharmacy team were appropriately trained or in accredited training programmes.

The trainee MCA had commenced her employment in the last two weeks and was in the process of being enrolled onto an MCA training course. She said she had read the SOPs which were relevant to her role and was currently being shown the various processes. She was familiar with the WWHAM questioning technique and said she would refer all sales to the pharmacist or another member of staff.

The normal staffing level was a pharmacist plus three staff in the morning, and two staff in the afternoon. The volume of work appeared to be managed. Staffing levels were maintained by a staggered holiday system. Relief staff could be requested from the head office but were rarely needed.

The pharmacy team had completed some training modules such as Dementia Friends and healthy living pharmacy. The training topics appeared relevant to the services provided and those completing the learning. But there was no structure as to how often they were provided. So learning needs may not always be addressed.

The dispenser gave an example of how she would help the MCA to sell a pharmacy only medicine using the WWHAM questioning technique and refer people to the pharmacist if needed.

The pharmacist said he felt able to exercise his professional judgment and he thought this was respected by the pharmacy team and head office.

A dispenser said she had commenced her role about 12 months ago and during this time she felt she received a good level of support from the pharmacy team and was able to ask for additional help if she needed it.

Appraisals were conducted each year by the pharmacist manager. A dispenser said the manager discussed her performance, training requirements and areas for improvement. She felt that the appraisal process was a good chance to receive feedback about her work.

Staff were aware of the whistleblowing policy in place and staff said they would be comfortable escalating concerns to the head office. There were targets set for MURs and NMS. But the pharmacist said he 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 allow private conversations.

Inspector's evidence

The pharmacy premises was clean and tidy, and appeared adequately maintained, but was showing signs of age. The size of the dispensary was sufficient for the workload. A sink and washing facilities were 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 use of a gate.

The temperature was controlled in the pharmacy by the use of electric heaters. Lighting was sufficient. The staff had access to a kettle, microwave, and WC facilities.

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

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's services are easy to access. And they are suitably managed to help make sure that they are provided safely. The pharmacy gets its medicines from appropriate sources, manages them safely and carries out regular checks to help make sure that all its medicines are in good condition.

Inspector's evidence

Access to the pharmacy was level via a single door and was suitable for wheelchair users. The consultation room was wheelchair friendly and the PMR system was capable of producing large print font.

Pharmacy practice leaflets gave information about the services offered. 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 using a signposting folder.

The pharmacy opening hours were displayed at the entrance of the pharmacy and a range of leaflets provided information about various healthcare topics.

A repeat prescription service was offered where patients could contact the pharmacy to order their medication. A record of requested medication was kept, and any missing items were queried with the GP surgery.

The pharmacy had a delivery service. Deliveries were segregated after their accuracy check and logged onto an electronic delivery management system. The driver used an electronic device to obtain a signature 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.

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.

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.

Schedule 3 and 4 CDs stored on collection shelves were not highlighted to indicate their presence. Which means there is a risk that 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. Educational

material was available to hand out when the medicines were supplied. The pharmacist said he has spoken to patients who were at risk and checked they were aware about the pregnancy prevention programme.

Some medicines were dispensed in multi-compartment compliance aids. Details of the medicines were recorded on each patient's PMR, but the pharmacy did not keep separate records to confirm current medication and dosage times for easy reference. This may increase the risk of the compliance aids being assembled incorrectly. Medication changes were confirmed with the GP surgery before being recorded on the patient's PMR. Hospital discharge sheets were sought. Disposable equipment was used to provide the service, and the compliance aids were labelled with medication descriptions and a dispensing check audit trail. But patient information leaflets (PILs) were not routinely supplied. So people may not always have all of the necessary information to take their medicines safely.

Prescriptions for dressings and ostomy supplies were sent to an external dispensing contractor. Consent was not normally obtained from the patient for the prescription to be dispensed by another contractor. So people may not always be aware that their information is being shared.

Medicines were obtained from licensed wholesalers. Unlicensed medicines were obtained from a specials manufacturer. The pharmacy was not yet fully compliant with the Falsified Medicines Directive (FMD). Suitable equipment was in place to complete safety checks. The pharmacy team said they were currently leaving safety checks to the pharmacist who would check the security seal during the final accuracy check and then scan the product. But written procedures were not yet in place and other members of staff were not completing this process. Aggregate codes were used to verify medicines at the point of handout.

Members of the pharmacy team said they would check the expiry dates of medicines on a monthly basis, but there were no records kept. This meant the pharmacy could not demonstrate when stock had been checked and there was a risk that some medicines could be overlooked. Short-dated stock was highlighted using a highlighter pen. Liquid medication did not always have the date of opening written on; including one CD solution which expired after three months of opening. So the pharmacy team may not be able to decide if the medicine remained fit for purpose. A spot check of 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. CD denaturing kits were available for use.

There was a clean medicines fridge with a thermometer. The minimum and maximum temperatures were being recorded daily and records showed that temperatures had been within the required range for the last three months.

Patient returned medication was segregated from current stock in designated bins for storing waste medicines located away from the dispensary.

Drug alerts were received electronically by email. 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

The pharmacy team has access to the equipment they need for the services they provide.

Inspector's evidence

The staff had access to the internet for general information. This included access to medicine information on 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, the majority had British Standard and Crown marks. Some measures were made of plastic without standardised markings. Which may not provide the degree of accuracy required for professional services. Separate measures were designated and used for CDs. The pharmacy also had counting triangles for counting loose tablets including a designated tablet triangle for cytotoxic medication.

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.