General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Platt Bridge Consortium LLP, 612 Liverpool Road, Platt Bridge, WIGAN, Lancashire, WN2 5BB

Pharmacy reference: 1033956

Type of pharmacy: Community

Date of inspection: 03/07/2019

Pharmacy context

This is a community pharmacy on a major road. It is situated in the residential area of Platt Bridge, near Wigan. The pharmacy dispenses both NHS and private prescriptions, sells over-the-counter medicines and provides a minor ailment service. 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. 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 keeps the records it needs to by law. People who work in the pharmacy are given training about the safe handling and storage of data. This helps to make sure that they know how to keep private information safe.

Inspector's evidence

There was a set of Standard Operating Procedures (SOPs) which had been recently updated. The pharmacy team were in the process of signing these to say they had read and accepted the SOPs. Dispensing errors were recorded on a standardised form and investigated by the pharmacist. The most recent error involved the incorrect dosage on the dispensing label of a medicine. The pharmacist said he would discuss errors with the pharmacy team.

Near miss errors were recorded on a paper log and the records were usually reviewed each month by the pharmacist. But reviews had not been completed since March 2019. So any learning identified from reviews may be delayed. The pharmacist said he would highlight mistakes to staff at the point of accuracy check and staff were asked to rectify their own errors. Actions were taken to help prevent errors being repeated, e.g. placing a "check address" alert alongside prescriptions for patients who have a similar name to others.

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. The responsible pharmacist (RP) had their notice displayed prominently.

The pharmacy had a complaints procedure. It was described in the practice leaflet and advised people to discuss their concern or feedback with members of the pharmacy team. Complaints were recorded on a standardised form to be followed up by the pharmacist manager or superintendent.

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. These were generally audited each month. Patient returned CDs were recorded in a separate register.

An information governance (IG) policy was available. This had been read by the pharmacy team and they had signed confidentiality agreements. When questioned, the dispenser was able to describe how confidential waste was segregated and removed by a waste carrier. Information about how the pharmacy handled patient information was on display in the retail area.

Safeguarding procedures were in place and had been read by the pharmacy team. The pharmacist said he had completed level 2 safeguarding training. Contact details of the local safeguarding board were on display in the dispensary. 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. 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 manager and five dispensers. All members of the team had completed the necessary training for their roles. The normal staffing level was a pharmacist and three dispensers. The volume of work appeared to be managed. Staffing levels were maintained by part-time staff and a staggered holiday system.

Members of the pharmacy team were provided with learning packages such as Dementia friends and Children’s oral health. The training topics appeared relevant to the services provided and those completing the learning. But these were not provided in a structured or consistent manner. So learning needs may not always be fully addressed.

The dispenser 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 judgment and this was respected by the superintendent and the company.

A dispenser had commenced her employment within the last seven months. She said she felt a good level of support from the pharmacist and the pharmacy team.Appraisals were conducted annually by the pharmacy 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 discuss her work.

Staff were aware of the whistle blowing policy and said that they would be comfortable escalating any concerns to the superintendent.Targets were not set by the company.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are suitable for the services provided. But the pharmacy does not have a consultation room, so it is unable to offer some services and private conversations may be difficult.

Inspector's evidence

The pharmacy was clean and tidy but was showing signs of age. Some floor tiles in the retail area were damaged, which may be a tripping hazard.The size of the dispensary was sufficient for the workload. 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 a counter.

The temperature was controlled by the use of heaters. Lighting was sufficient.The staff had access to a kettle, microwave, separate staff fridge, and WC facilities.There was no consultation room to enable a private conversation. The pharmacist said he was mindful of what he discussed in front of others in the retail area and said he would wait to speak to people when it was quieter. But this may be difficult as there is regular footfall into the pharmacy.

Principle 4 - Services ✔ Standards met

Summary findings

Some people, including wheelchair users, may find it difficult to enter the pharmacy. So they may not be able to access all of the pharmacy's services. Services are managed to help make sure that they are provided safely. But the pharmacy does not always highlight important information about medicines that are waiting to be collected. So the pharmacy team may not always check that the medicines are still suitable, or give people advice about taking them. The pharmacy gets its medicines from appropriate sources, stores them appropriately and carries out regular checks to help make sure that they are in good condition.

Inspector's evidence

Access to the pharmacy was via a single door with a step. Staff said they would provide assistance to those who needed extra help, but some wheelchair users were not able to enter.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 signposting information.

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 would 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 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.

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 CDs were highlighted so that staff could check prescription validity at the time of supply. However; schedule 4 CDs were not. 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. Educational material was available to hand out when the medicines were supplied. The pharmacist said he would

speak to patients to check the supply was suitable but said there were currently no relevant patients that met the risk criteria.

Some medicines were dispensed in MDS compliance aids. A bespoke computer programme contained the details of people's current medication. Any medication changes were logged onto a query function on the programme and the GP surgery was contacted before the record 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 MDS packs were labelled with medication descriptions and a dispensing check audit trail. Patient information leaflets (PILs) were routinely supplied.

Medicines were obtained from licensed wholesalers, with unlicensed medicines sourced from a special's 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 every two months. A diary was used 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 recorded in the diary for it to be removed at the start of the month of expiry. 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 was a clean medicines fridge with a minimum and maximum thermometer. The minimum and maximum temperature was being recorded daily and records showed they had been within the required range for the last three months.

Patient returned medication was disposed of in DOOP bins 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's team members have 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 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.

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.

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.