General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Standish Pharmacy Ltd, 15 Preston Road, Standish, WIGAN, Lancashire, WN6 0HR

Pharmacy reference: 1033973

Type of pharmacy: Community

Date of inspection: 18/06/2019

Pharmacy context

This is a community pharmacy based on a high street. It is situated near a major crossroad through the town centre of Standish, north of Wigan. The pharmacy dispenses NHS prescriptions, private prescriptions and sells over the counter medicines. It also provides a range of services including a minor ailment service and emergency hormonal contraception. A number of people receive their medicines in multicompartment compliance aids.

Overall inspection outcome

Standards not all met

Required Action: Improvement Action Plan

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 not all met	4.2	Standard not met	Pharmacy services do not always operate safely and effectively, specifically: Prescription forms are not retained until the medicines are supplied. This means the pharmacy team may not have all the information they need and sometimes may not be able to comply with legal requirements Delivery records are not retained, which means the pharmacy cannot demonstrate that the medicines were supplied appropriately There is no dispensing audit trail to identify who dispensed or checked medicines, which may increase the risk of a supply which has not been suitably checked by the pharmacist
		4.3	Standard not met	The pharmacy does not effectively control the fridge temperatures. So they cannot provide assurances that fridge medicines are always stored appropriately.
5. Equipment and facilities	Standards not all met	N/A	N/A	N/A

Principle 1 - Governance ✔ Standards met

Summary findings

The pharmacy has written instructions to help make sure that members of staff work safely and effectively. But the instructions have not been reviewed for several years so some may be out of date. Members of the pharmacy team do not always make records of things that go wrong. So they may miss opportunities to learn from them and prevent the same mistakes happening again. The pharmacy keeps most of the records it needs to by law. Members of the pharmacy team have not read or signed data protection policies and confidentiality agreements. So the company cannot provide assurance that staff always know how to protect people's information. The pharmacy does not have clear safeguarding procedures in place. So concerns about vulnerable people may not always be identified or addressed.

Inspector's evidence

There was a set of Standard Operating Procedures (SOPs) which were issued in 2010. These had not been reviewed, so they may not reflect current practice. Most of the pharmacy team had signed to say they had read and accepted the SOPs, but a counter assistant had not. So she may not always understand what is expected of her.

Dispensing errors were recorded electronically. But the superintendent (SI) said some errors were not recorded e.g. when the medicine had not been taken by the patient. The latest error to be recorded involved the incorrect assembly of a compliance pack. The pharmacist had investigated the error and discussed it with the pharmacy team. There was a form available to record when near miss errors occurred. But it was not in use. The pharmacist said he would highlight mistakes to staff at the point of accuracy check and ask them to rectify their own errors. The pharmacy team had responded to some near miss errors by placing "take care" stickers in the dispensary locations similarly named medicines.

A matrix in the SOPs indicated pharmacy team roles and responsibilities. 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. The pharmacy had a complaints procedure, but there was no information on display to tell people how to make complaints or give feedback. Any complaints received would be recorded on a standardised form to be followed up by the SI. A current certificate of professional indemnity insurance was provided.

The responsible pharmacist (RP) had their notice displayed prominently and was signed in to the RP register. But the pharmacist consistently failed to record the end of their tenure. So the company may not always be able to show when a responsible pharmacist was present. Private prescriptions and emergency supplies were recorded electronically. But emergency supply records did not always state the nature of the emergency. So the pharmacy may not be able to show that supplies are always appropriate.

An information governance (IG) policy was available. But it had not been updated since the change in legislation to include GDPR procedures. The pharmacy team had not read or signed the IG policy and had not signed confidentiality agreements. The company did not have a privacy notice about how they handled patient information so may not be meeting legal requirements. When questioned, the dispenser understood the need to protect confidentiality and gave an example that she would be

careful not to display confidential information on the counter.

The pharmacy did not have a safeguarding policy in place and there were no contact details of the local safeguarding board available. The pharmacist said he had completed level 2 safeguarding training. 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. But members of the pharmacy team rarely participate in ongoing training, so their knowledge may not always be up to date.

Inspector's evidence

The pharmacy team included a pharmacist, two dispensers, a medicine counter assistant (MCA) and two drivers. All members of the pharmacy team had completed the necessary training for their roles. The normal staffing level was a pharmacist and two to three staff. The volume of work appeared to be managed. Staffing levels were maintained by part-time staff and a staggered holiday system.

There were few learning activities completed by the pharmacy team. A dispenser said she would read pharmacy press magazines to keep up to date with new products. But this was not recorded and was completed infrequently. So learning may not always be addressed.

The 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 dispenser said she felt able to ask for further help if she needed it. But staff were not given appraisals or formal feedback about their work, which would help staff development and to identify specific learning needs. Staff were aware of how to escalate any concerns to the SI. There were no service-based targets 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, and appeared adequately maintained. 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 use of a gate. The temperature was controlled in the pharmacy by the use of an air conditioning unit. Lighting was sufficient. The staff had access to a kettle, and WC facilities.

The pharmacy did not have a consultation room. The pharmacist said as footfall into the pharmacy was low, he would ask people to wait until the retail space was empty before discussing personal information.

Principle 4 - Services **Standards not all met**

Summary findings

The pharmacy's services are easy to access. The pharmacy's services are not always effectively managed. This means the pharmacy team do not always have all the information they might need about the medicines they supply. And so there is more chance that things could go wrong. The pharmacy does not always monitor the fridge temperatures. So they cannot provide assurances that these medicines are always stored at the correct temperature.

Inspector's evidence

Access to the pharmacy was level via a single door and was suitable for wheelchair users. Information about the services offered was displayed. Pharmacy staff were able to list and explain the services provided by the pharmacy. The pharmacy opening hours were displayed.

A repeat prescription service was offered where patients would contact the pharmacy to order their medication. But a record of requested medication was not kept. So in the event of a query, the pharmacy team may not be sure which medicines were ordered. 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.

Prescriptions were labelled by the pharmacist and dispensed one at a time. The dispenser would pick the items and the pharmacist would check the medication and attach the label. There was no audit trail to identify who dispensed or checked medicines. This would help to provide learning to specific members of the pharmacy team in the event of a mistake being made.

Dispensed medicines awaiting collection were segregated away from the dispensing area on a collection shelf using an alphabetical retrieval system. Prescription forms were not always retained. So the pharmacy team may not have all of the information they may need when medicines are handed out. Stickers were used to clearly identify when fridge or CD safe storage items needed to be added.

Schedule 3 and 4 CDs were not highlighted. So there is a significant risk that these medicines could be supplied after the prescription had expired. And because the prescription forms are not retained the pharmacist will not be able to endorse the date when schedule 3 CDs are supplied, which is a legal requirement. High risk medicines (such as warfarin, lithium and methotrexate) were also not 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 any patients who were at risk and make them aware of the pregnancy prevention programme. The pharmacy team said they were not aware of any current patients who met the risk criteria.

Some people receive their medicines in compliance packs. Records about dosage times were not kept to help with their assembly, which may increase the risk of the packs being assembled incorrectly. Disposable equipment was used to provide the service. But MDS packs 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.

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. Computer software was installed but there was no equipment to scan barcodes on medicines. The SI said he had yet to arrange for the purchase of scanning equipment.

Members of the pharmacy team said stock was date checked routinely during a quiet period. But this was not always recorded and there was no formal date checking programme. So there is a risk that some medicines may be overlooked. Short dated stock was removed 2 months in advance of it expiring. A spot check of medicines did not find any out of date stock.

There was a clean fridge with a minimum and maximum thermometer. But daily records of the temperature were not kept. The temperature of the fridge was seen at -1.1C and 1.6C and 7.6C during the inspection. So the pharmacy cannot provide assurances that medicines are always stored in their licensed conditions. 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. Some out of date CD stock had not been destroyed since 2014. This increases the risk of an error. Patient returned medication was disposed of in DOOP bins located away from the dispensary. Drug alerts were received electronically by email and the SI said he would action these when they were received. But there was no audit trail kept about the action taken. So the pharmacy cannot demonstrate that these had been suitably actioned.

Principle 5 - Equipment and facilities **Standards not all 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 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. 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.

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.