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: 17/02/2020

Pharmacy context

This is a community pharmacy located 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 minor ailment service. 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	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 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 But the instructions have not been reviewed for several years so some may be out of date. The pharmacy keeps most of the records it needs to by law. But members of the pharmacy team have not read or signed data protection policies or confidentiality agreements. So the company cannot provide assurance that staff always know how to protect people's information. And they 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.

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. An example of an error involved the incorrect assembly of a compliance pack. The pharmacist had investigated the error and discussed it with the accuracy checker. There was a form available to record when near miss errors occurred, but it was not in use. The pharmacy team said if the pharmacist found an error during the final accuracy check, he would highlight the mistake to staff at the time and asked them to rectify their own errors. Members of the team said they kept the dispensary stock tidy to help prevent picking errors. But there were few examples of action which had been taken to help prevent similar mistakes being repeated.

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 superintendent (SI). A current certificate of professional indemnity insurance was seen.

The responsible pharmacist (RP) had their notice displayed prominently and was signed in to the RP register. But the RP records did not 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. Records of private prescriptions and emergency supplies appeared to be in order. Controlled Drugs (CDs) registers were maintained. But there were no regular audits of the running balances. So mistakes or errors may go unnoticed for some time. Three balances were checked and two were found to be correct. The third balance found a discrepancy. The superintendent (SI) had been informed about the discrepancy and had said he would investigate it. Patient returned CDs were recorded in a separate register.

Information governance (IG) procedures were in place. But members of the pharmacy team had not read or signed an IG policy and had not signed confidentiality agreements. When questioned, the dispenser understood the need to protect confidentiality and explained that she segregated confidential waste for it to be destroyed using the onsite shredder. A privacy notice was on display and described how confidential information was handled and stored by the pharmacy.

A safeguarding policy was available, but there were no contact details for the local safeguarding board available. Members of the team said they had read the policy and 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 – who was the SI, two dispensers, a medicine counter assistant (MCA) and two delivery drivers. All members of the pharmacy team had completed the necessary training for their roles. The normal staffing level was a pharmacist and two other staff. The volume of work appeared to be managed. Staffing levels were maintained by part-time staff and a staggered holiday system. A locum pharmacist was present during the inspection.

There were few learning activities completed by the pharmacy team. A dispenser said the pharmacist would discuss new products available with members of the team. But further training material was not available. 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 medicines that were liable to misuse that she felt were inappropriate and refer people to the pharmacist if needed. The locum pharmacist said he felt able to exercise his professional judgment, and this was respected by the pharmacy team and the SI. 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. 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. But there was a low footfall into the pharmacy, so it was unlikely that private conversations would be overheard.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's services are easy to access. It gets its medicines from recognised sources, stores them appropriately and carries out some 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 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. 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. The locum pharmacist said he would sign the label, but other members of the pharmacy team did not. So in the event of a mistake being made it may not always be possible to identify who was involved.

Dispensed medicines awaiting collection were segregated away from the dispensing area on a 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 always 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. Members of the pharmacy team said the pharmacist had spoken to patients who were at risk and had made them aware of the pregnancy prevention programme. They were not aware of any current patients who met the risk criteria.

Some people received their medicines in compliance packs. Before a person was started on a compliance aid the pharmacy would refer them to their GP to complete an assessment about their suitability. Disposable equipment was used to provide the service. But compliance 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, 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 checks of medicines. Members of the pharmacy team said they would routinely check the expiry dates of stock every few weeks. 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 highlighted using a sticker. A spot check of medicines did not find any out of date 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. Some out of date CD stock had not been destroyed since 2014. This increases the risk of an error. There was a clean medicines fridge with a thermometer. A sheet was used to record the minimum and maximum temperature, but there were a number of gaps in the records. So the pharmacy may not be able to always show the temperature was always within range. The thermometer indicated the temperature remained within the appropriate range during the inspection. Patient returned medication was disposed of in DOOP bins located away from the dispensary. Drug alerts were received electronically by email. Members of the pharmacy teal said the SI would action these when they were received. But there was no audit trail 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.

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 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.

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.