General
Pharmaceutical
Council

Registered pharmacy inspection report

Pharmacy Name: Abram Pharmacy, 358 Warrington Road, Abram, WIGAN, Lancashire, WN2 5XA

Pharmacy reference: 1033984

Type of pharmacy: Community

Date of inspection: 22/06/2021

Pharmacy context

This is a community pharmacy located in the small village of Abram, part of the Borough of Wigan. A GP practice is located opposite the pharmacy. 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. The pharmacy supplies medicines in multi-compartment compliance aids for some people to help them take the medicines at the right time. The inspection was conducted during the COVID-19 pandemic.

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 not all met	3.1	Standard not met	The consultation room is used to store returned needles, some of which are not being kept in appropriate containers. This a health & safety risk to people who use the consultation room.
4. Services, including medicines management	Standards not all met	4.3	Standard not met	Medicines are sometimes kept in containers that are not air-tight, while they are being dispensed. This may affect their stability and so the pharmacy cannot provide assurance that they are always fit for purpose.
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. Members of the team record things that go wrong, but they do not review the records, so they may miss some learning opportunities. And there may be a risk of similar mistakes happening again.

Inspector's evidence

There was a set of standard operating procedures (SOPs) which had been issued in 2016. But there was no stated date of review. So it was not known whether the SOPs reflected current practice. Members of the pharmacy team had signed to say they had read and accepted the SOPs.

Details of near miss incidents and dispensing errors were recorded on an electronic recording system. A dispenser explained that the pharmacist would also highlight mistakes to staff at the point of accuracy check and ask them to rectify their own errors. But there were no reviews of the error records, and staff could not show any examples of action that had been taken to help prevent similar mistakes. So some learning opportunities may be missed.

There were two responsible pharmacist (RP) notices on display. So it may not be clear to the people who the responsible pharmacist at a specific time. 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. Staff wore standard uniforms. The pharmacy had a complaints procedure, but there was no information about it on display. So people may not always be aware how to provide feedback to the pharmacy, or escalate any concerns. A current certificate of professional indemnity insurance was on display.

Records for the RP, private prescriptions and emergency supplies appeared to be in order. Controlled drugs (CDs) registers were maintained with running balances recorded and checked monthly. 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 GDPR training. When questioned, a dispenser was able to describe how confidential waste was segregated and destroyed by incineration. There was no information on display to tell people about how their information was handled by the pharmacy.

Safeguarding procedures were included in the SOPs and the pharmacy team had completed safeguarding training. The locum pharmacist said he had completed level 2 safeguarding training. But staff were unsure about where the contact details for the local safeguarding board were, so this could delay reporting in the event of a concern. A 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 appropriately trained for the jobs they do. Members of the pharmacy team complete regular training to help them keep their knowledge up to date.

Inspector's evidence

The pharmacy team included a pharmacist – who was the superintendent (SI), six dispensers and a driver. All members of the team had completed the necessary training for their roles. The normal staffing level was a pharmacist and four to five dispensers. The volume of work appeared to be managed. Staffing levels were maintained by a staggered holiday system.

Members of the pharmacy team completed some additional training, for example they had recently completed training packs about antibiotic stewardship and suicide prevention. Certificates for completed training were kept as records to show which training had been completed by members of the team. A dispenser gave examples of how she would sell a pharmacy only medicine using the WWHAM questioning technique, refuse sales of medicines she felt were inappropriate, and refer people to the pharmacist if needed. The locum pharmacist said he felt able to exercise his professional judgement and this was respected by the company directors.

The dispenser said she felt a good level of support from the pharmacist and was able to ask any questions. Appraisals were conducted quarterly by the company. A dispenser said she received feedback on her performance, and she was able to speak about any of her own concerns if she had any. Staff were aware of the whistleblowing policy and said that they would be comfortable reporting any concerns to the SI. There were no professional based targets in place.

Principle 3 - Premises Standards not all met

Summary findings

The pharmacy premises are suitable for the services provided. But the presence of stock on the floor presents a tripping hazard. A consultation room is available to enable private conversations. But it is used to store returned medicines which is a security risk.

Inspector's evidence

The premises were clean and appeared adequately maintained. The size of the dispensary was sufficient for the workload. The temperature was controlled by the use of electric fans and heaters. Lighting was sufficient. The staff had access to a kitchenette and WC facilities. Additional storage space was available in the upstairs storage rooms.

A number of drink feeds and thickeners were being stored in the retail area and a box of drink feeds was being used to prop open the entrance door. Several dispensing baskets were being stored on the dispensary floor despite space being available on the worktops.
Only two people were permitted in the retail area at any one time. Staff were wearing masks. They had all had their 2nd COVID vaccination and were all completing twice-a-week lateral flow tests to check for any asymptomatic COVID infections. Hand sanitiser was available.

A consultation room was available with access restricted by use of a lock. A number of yellow sharps bins were being stored in the consultation room, and some pre-filled insulin pens that had not been placed inside of the sharps bins.

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

Summary findings

The pharmacy's services are easy to access. The pharmacy team has some systems in place to help make sure they supply medicines safely. But medicines for care home patients are sometimes kept in cardboard cartons for long periods while they are being dispensed. And these cartons are not airtight. So the pharmacy cannot show that the medicines will always be fit for purpose. And 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. Various leaflets gave information about the services offered and other healthcare topics. The pharmacy opening hours were displayed

The pharmacy had a delivery service. This had been adapted in response to current COVID guidance. The delivery driver would leave the patient's bag of medicines at the door, knock, and stand back to allow social distancing whilst the patient picked up the bag. If there was no answer the medicines would be returned to the pharmacy. A paper record was kept as an audit trail.

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. 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. There was no process to highlight dispensed medicines containing schedule 3 and 4 CDs, or high-risk medicines (such as warfarin, lithium and methotrexate). So staff may not always know whether a prescription has expired when they hand out the medicines, or know when patients may need counselling. 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 staff said the pharmacist would speak to patients who were at risk to make sure they were aware of the pregnancy prevention programme. But they were not aware of any current patients who met the risk criteria.

Some medicines were dispensed in multi-compartment compliance aids. Before a person was started on a compliance aid the pharmacy would complete an assessment of their suitability and inform their GP surgery. An electronic record was kept for each patient, containing details about their current medication. Any medication changes were confirmed with the GP surgery before the record was amended. Hospital discharge information was sought when necessary. Disposable compliance aids were used to provide the service. But they were not labelled with medication descriptions and patient information leaflets (PILs) were not routinely supplied. So people may not always have all the information they need to take their medicines safely.

The pharmacy dispensed medicines for a number of patients who were residents of care homes. A re-order sheet was provided to the pharmacy and it contained details about the medicines required, medicine changes and any handover notes for the pharmacy. When prescriptions were received from the GP surgery, they would be compared to the re-order sheet to confirm all medicines had been received back. Any queries were written onto a query sheet and chased up with the GP surgery by either the care home or the pharmacy team. For some care homes, medicines were dispensed into disposable compliance aids. When these were assembled, a dispenser would use a de-blistering machine to remove tablets from their original packs. The dispenser would then place the loose tablets back into the original cardboard medicine box until they were ready to fill the compliance aid. Some of the medicines present in cardboard boxes had been de-blistered the previous day. The cardboard boxes were not airtight, so they offered little protection of the medicines from the atmosphere. The pharmacy had not carried out any risk assessment of this practice and could not provide any assurance that the stability of the medicines was not affected.

Stock medicines were obtained from licensed wholesalers, and any unlicensed medicines were sourced from a specials manufacturer. Stock was date checked every 3 months. The staff said a date checking book was used as a record of what had been checked, but they were not able to locate it. So there is a risk some medicines may be overlooked. Liquid medication did not always have the date of opening written on so the pharmacy team may not know when they were opened or whether the medicines are still suitable for supply.

Controlled drugs were stored appropriately in the CD cabinets, with 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 generally remained in 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 electronically on the error reporting system. But the details of the action taken were not recorded. So the pharmacy may not be able to always show they have taken appropriate action in response to alerts.

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. 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.