General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: J Morris Pharmacy Limited, 109 Wigan Road, Ashton-in-Makerfield, WIGAN, Lancashire, WN4 9BH

Pharmacy reference: 1033995

Type of pharmacy: Community

Date of inspection: 07/01/2020

Pharmacy context

This is a community pharmacy located near to a GP surgery. It is situated in the residential area of Ashton-in-Makerfield, in the borough 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. 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

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Summary of notable practice for each principle

Principle	Principle finding	Exception standard reference	Notable practice	Why
1. Governance	Standards met	1.7	Good practice	Members of the pharmacy team are given training so that they know how to keep private information safe.
2. Staff	Good practice	2.2	Good practice	Members of the pharmacy team complete regular training modules to help them keep their knowledge up to date
		2.4	Good practice	Members of the pharmacy team have regular meetings to discuss how they can learn or improve. And the meetings are recorded for future reference.
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. 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. They record and review things that go wrong, to help identify learning and reduce the chances of similar mistakes happening again.

Inspector's evidence

There was a current set of standard operating procedures (SOPs) which were routinely updated by the superintendent (SI). Members of the pharmacy team had signed to say they had read and accepted the SOPs.

Dispensing errors were recorded electronically on the national error reporting and learning website. A recent error involved the incorrect supply of clomipramine 25mg capsules instead of 50mg capsules. A pharmacist had investigated the error and shared their findings with members of the pharmacy team. Near miss incidents were recorded on a paper log. Members of the pharmacy team explained that a pharmacist would review the near miss records each month. The pharmacist would record the details and share their findings with members of the team. They said the pharmacist would also highlight mistakes to staff at the point of accuracy check and ask them to rectify their own errors. They provided examples of action which had been taken in response to near misses, such as highlighting the different strengths of fluoxetine capsules. The pharmacist also shared learning from the NPA's quarterly patient safety bulletin, and this was recorded in the team meeting records.

Roles and responsibilities of the pharmacy team were described in individual SOPs. A trainee 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. The pharmacy had a complaints procedure. A notice in the retail area advised people they could discuss any concerns or feedback with members of the pharmacy team. Any complaints would be recorded to be followed up by the superintendent (SI). A current certificate of professional indemnity insurance was on display. Two responsible pharmacist (RP) notices were being displayed so people could be confused about who the RP was.

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. The pharmacist said he would check the balance when CD medicines were dispensed. 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. The pharmacy team had completed GDPR training and each member had signed a confidentiality agreement. When questioned, a dispenser was able to describe how confidential waste was segregated before being destroyed using an on-site shredder. A poster on display in the retail area provided details about how the pharmacy handled people's data.

Safeguarding procedures were included in the SOPs. The pharmacy team had in-house safeguarding training and the pharmacist said he had completed level 2 safeguarding training. Contact details for the local safeguarding board were available. A dispenser said she would initially report any concerns to the

pharmacist on duty.

Principle 2 - Staffing ✔ Good practice

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 modules to help them keep their knowledge up to date. They get feedback from their manager and have regular team meetings to help them learn and improve.

Inspector's evidence

The pharmacy team included two pharmacists – one of who was the SI, and five dispensers – one of whom was in training. Members of the pharmacy team were appropriately trained or on accredited training programmes. During the morning the normal staffing level was a pharmacist and four dispensers. During the afternoon, there were two pharmacists and three dispensers. The volume of work appeared to be managed. Staffing levels were maintained by part-time staff, locum dispensers and a staggered holiday system. At the time of the inspection the SI was present, and the second pharmacist arrived partway through.

The pharmacy provided members of the team with learning resources, such as training booklets, e-learning, and in-house training. The training topics appeared relevant to the services provided. Training records were kept showing that ongoing training was routinely completed. Staff were allowed learning time to complete the training.

The trainee dispenser gave examples of how she would sell a pharmacy only medicine using the WWHAM questioning technique, refuse sales of medicines that were liable to abuse if she felt they were inappropriate, and refer people to the pharmacist if needed. A pharmacist said they felt able to exercise their professional judgment and this was respected by the pharmacy team. A dispenser said she felt a good level of support from the pharmacist and felt able to ask for further help if she needed it.

Appraisals were conducted annually by a pharmacist. A dispenser said she felt that the appraisal process was a good chance to receive feedback and she felt able to speak about any of her own concerns. The staff held weekly huddles about issues that had arisen, including when there were errors or complaints. Minutes of the meeting were recorded and emailed to each member of the pharmacy team as a record so that it could be shared with staff who were not present. Staff were aware of the whistleblowing policy and said that they would be comfortable reporting 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. A consultation room is available to enable private conversations.

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 to the dispensary was restricted by the position of the counter. The temperature was controlled by the use of air conditioning. Lighting was sufficient. The staff had access to a kettle, microwave, separate staff fridge, and WC facilities.

A consultation room was available. The space was clutter free with a desk, seating, adequate lighting, and a wash basin. The patient entrance to the consultation room was clearly signposted.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's services are easy to access. Its working practices are generally safe and effective. It gets its medicines from recognised sources, stores them appropriately and carries out regular 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 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. There was also wheelchair access to the consultation room. Various posters 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 elsewhere using a signposting folder. The pharmacy opening hours were displayed 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 recorded on a delivery sheet. Unsuccessful deliveries would be returned to the pharmacy and a card posted through the letterbox indicating the pharmacy had attempted a delivery. The delivery driver sometimes posted medicines through letter boxes. This only happened if the patient had given permission, but the pharmacy did not always check to make sure circumstances had not changed. And they could not show that they had properly thought about all of the risks that might be involved. This means the pharmacy could not show that it was safe to leave medicines in this way.

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. Prescription forms were not always retained. So the pharmacy team may not have all of the information they need when medicines are handed out. Stickers and laminates 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 segregated and kept with the prescription form so that staff could check the prescription was still valid at the time of supply. But schedule 4 CDs were not, so there was 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 were not always aware when they were being handed out in order to check that the supply was 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 SI said he had completed an audit and he would speak to any patients who were at risk to make sure they were aware of the pregnancy prevention programme, which would be recorded on their PMR.

Some medicines were dispensed in multi-compartment compliance aids. Before a person was started on a compliance aid the pharmacist would complete an assessment about their suitability. A record sheet was kept for each patient, containing details about their current medication. Any medication changes were confirmed with the GP surgery before the record sheet 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 compliance aids were labelled with medication descriptions and a dispensing check audit trail. Patient information leaflets (PILs) were routinely supplied.

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. Stock was date checked on a 3-monthly basis. A date checking matrix was signed 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 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 thermometer. The minimum and maximum temperatures were being recorded daily and records showed they had been within the required range. Patient returned medication was disposed of in designated bins. Drug alerts were received by email from the MHRA. Alerts were printed, action taken was written on, initialled and signed by the person completing the checks.

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 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. 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.