General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Well, 60 Bickerstaffe Street, ST. HELENS, Merseyside, WA10 1DS

Pharmacy reference: 1034693

Type of pharmacy: Community

Date of inspection: 19/08/2019

Pharmacy context

This is a community pharmacy near the main bus station in the town centre of St Helens, Merseyside. 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 smoking cessation supplies. 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	Good practice	1.2	Good practice	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.
		1.8	Good practice	The pharmacy team have received safeguarding training and can provide examples of concerns that had been raised.
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 ✔ Good practice

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. They are given training so that they know how to keep private information safe. And they can provide examples of suitably raised safeguarding concerns. The pharmacy generally keeps the records it needs to by law.

Inspector's evidence

There was an electronic set of standard operating procedures (SOPs) which were regularly updated by the head office. The pharmacy team had read the procedures and completed an electronic assessment to check they understood them.

Dispensing errors were recorded electronically and submitted to the superintendent (SI). A recent error involved the supply of medicines to the wrong person. The pharmacist and pharmacy manager had investigated the error and completed a root cause analysis. The pharmacy team were made aware about the error and retraining has been arranged for the staff involved. Near miss errors were recorded on a paper log and the records were reviewed monthly by the pharmacist. The pharmacist said she would consider underlying factors as part of the review and discuss it with staff each month. The pharmacist would also highlight mistakes to staff at the point of accuracy check and asked them to rectify their own errors. She gave examples of action taken to help prevent similar mistakes, such as segregating similar medicines away from one another. For example, pregabalin and gabapentin were located away from other medicines. The company shared learning between pharmacies. Amongst other topics they covered common errors. The pharmacy team would discuss the information when it was received. Action had been taken to prevent a similar error occurring in the pharmacy, by changing their multi-compartment compliance aid process. They did this by using clear polythene bags to store assembled compliance aids, so that only the information on the packs was used to identify the patient. This removed the need to add an address label on the external bags and reduced the likelihood of them being supplied to the wrong person.

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 standard uniforms and had badges identifying their names and roles. The pharmacy had a complaints procedure. A poster in the retail area advised people how they could give feedback to members of the pharmacy team or to the company's head office. Complaints were recorded to be followed up by the pharmacy manager or head office. The company had a mystery shopper programme which would assess the quality of the pharmacy's customer service once every quarter. Following the visit, the pharmacy team were provided with a report and feedback. On the last three occasions the pharmacy had passed without areas to improve.

A current certificate of professional indemnity insurance was seen. The responsible pharmacist (RP) had their notice displayed prominently and was appropriately signed in to the RP register. But a locum had not entered their details on 5th July 2019, so the records were incomplete. Controlled drugs (CDs) registers were maintained with running balances recorded and checked weekly. The balance of MST 10mg MR tablets and Longtec 10mg MR tablets were checked and both found to be accurate. Patient

returned CDs were recorded. Private prescription and emergency supply records appeared to be in order. Records of unlicensed specials did not always contain the required details of when they were supplied and to whom.

An information governance (IG) policy was available. The pharmacy team completed IG training and had signed confidentiality agreements. When questioned, the dispenser was able to describe how confidential waste would be segregated for collection by a waste carrier. The company's privacy notice had been moved and was currently not on display.

Safeguarding procedures were included in the SOPs and had been read by the pharmacy team. The pharmacist said she had completed level 2 safeguarding training. Contact details of the local safeguarding board were available. The dispenser said she would initially report any concerns to the pharmacist on duty. An example of a safeguarding concern was provided which involved a patient whose carers were providing medicines at the incorrect times. The pharmacy had raised this as a safeguarding concern and the patient was moved into a care home until new carers were arranged.

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. They get regular feedback from their manager to help them improve.

Inspector's evidence

The pharmacy team included a pharmacist and three dispensers – one of whom was the pharmacy manager. All members of the team had completed the necessary training for their roles. The normal staffing level was a pharmacist and two dispensers in the morning, and one dispenser in the afternoon. The volume of work appeared to be managed. Staff coverage was organised in sync with a nearby branch, who would provide cover during absences. The pharmacy manager split their hours between the two branches.

The company provided the pharmacy team with a structured e-learning training programme about the company’s procedures and services. Additional learning modules were available to complete but they were not compulsory and were not often completed by members of the pharmacy team. 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 she felt able to exercise her professional judgment and this was respected by the pharmacy manager and the company. The dispenser said she received a good level of support from the pharmacy team and felt able to ask for further help.

Appraisals were conducted by the pharmacy manager. 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 daily huddles about issues that had arisen, including when there were errors or complaints. A communications diary was used to record important information 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 manager or head office. The company set service-based targets for MURs and NMS. The pharmacist said she did not feel under pressure to achieve these.

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 appeared adequately maintained. But the pharmacy team appeared to be behind with their cleaning schedule as the floor required sweeping. 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. The temperature was controlled by the use of electric heaters and portable air conditioning units. Lighting was sufficient. The staff had access to a kettle, microwave, separate staff fridge, and WC facilities.

A consultation room was available with access restricted by use of a lock. The space was clutter free with a computer, 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. And it manages and provides them safely. It gets its medicines from appropriate sources, stores them appropriately and carries out regular checks to help make sure that they are in good condition. The pharmacy team carries out additional checks for people who receive higher-risk medicines to check that the medicines are still suitable.

Inspector's evidence

Access to the pharmacy was level via a single door and was suitable for wheelchair users. There was wheelchair access to the consultation room. Pharmacy practice leaflets gave information about the services offered. There was also information available on the company's website. 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 a signposting folder. The pharmacy opening hours were displayed at the entrance of the pharmacy and a range of leaflets provided information about various healthcare topics.

The pharmacy had a delivery service. Deliveries were segregated after their accuracy check and a 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. A second signature was obtained for the delivery of CD medicines to confirm receipt.

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 a numerical retrieval system. Prescription forms were retained, and stickers were used to clearly identify when fridge or CD safe storage items needed to be added. When people came to collect their medicines, the pharmacy team would search for a patient name on a handheld electronic device. This had a record of the location of the person's medicine. Confirmation of the person's address would be obtained by the member of the pharmacy team before they scanned the shelf and the barcode on the bag. This would need to match the recorded data otherwise a red warning would appear indicating it was the incorrect medicines. This helps to reduce the likelihood of a supply to the incorrect person.

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 highlighted using a sticker, and patients were counselled on their latest results. 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 she would speak to any patients who were at risk and make them aware of the pregnancy prevention programme, which would be recorded on their PMR.

Some prescriptions were dispensed by an automated hub as part of the company's central fulfilment programme. Verbal consent was obtained and recorded on the patient's PMR. Prescriptions were labelled electronically, before the pharmacist would complete the accuracy and clinical check on the information entered by the dispenser. This was sent to the hub, and the PMR indicated any items which could not be dispensed. This included items out of stock, not stocked, or CD and fridge items. The process was auditable by use of a personal log in to identify who had labelled the prescription and who performed the accuracy and clinical check. Prescriptions were received within 48 hours from the hub in a sealed tote that clearly identified that it contained dispensed medicines. When the dispensed medicines were received in branch they were matched up against the prescription and these did not need to be accuracy checked by the pharmacist. Any other items not dispensed by the hub were dispensed and checked by the branch.

Some medicines were dispensed in multi-compartment compliance aids. A record sheet was kept for each patient, containing details of 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.

Supplies of methadone were assembled using the automated Methameasure system. Methadone was stored in the CD cupboard overnight and inserted into the machine in the morning. Calibration volumes of 100ml, 50ml and 10ml were checked each day and the machine was cleaned. A log was initialled by the member of staff who completed this. When the patient collected their methadone, it was poured into a labelled cup or bottle by a member of the pharmacy team. This was then checked against the prescription by the pharmacist before supplying it to the patient.

Prescriptions for dressings and ostomy supplies were sent to be dispensed by an external appliance contractor. The pharmacy manager said that verbal consent was obtained from the patient for the prescription to be dispensed by another contractor and recorded on their PMR. Medicines were obtained from licensed wholesalers, with unlicensed medicines 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 safety checks of medicines. Stock was date checked on a 3-month rotating cycle. An electronic date checking matrix recorded what had been checked and by whom. 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 cabinets, 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 generally been within 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, and the action taken was recorded electronically before being printed and filed.

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. According to the stickers attached, all electrical equipment had been PAT tested in February 2018. 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. 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.