General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Ironbridge Pharmacy, The Square, Ironbridge, TELFORD, Shropshire, TF8 7AQ

Pharmacy reference: 1036078

Type of pharmacy: Community

Date of inspection: 12/08/2019

Pharmacy context

This is a community pharmacy located in the centre of the historic town of Ironbridge. It provides pharmacy services to the local population and is also used by tourists visiting the world heritage sites in the surrounding area. The pharmacy dispenses NHS prescriptions and provides medicines in multi-compartment compliance aid packs to help people take their medicines at the right time. It delivers medicines to people who are housebound and offers several other NHS services including Medicines Use Reviews (MURs). The pharmacy also sells a range of over-the-counter medicines and serves as a post office for the local community.

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	4.3	Standard not met	The pharmacy does not carry out enough checks to make sure medicines are stored appropriately and are suitable for supply.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance ✔ Standards met

Summary findings

The pharmacy identifies and manages risks adequately. It has written procedures to help make sure team members complete tasks safely. But they are not always properly followed, so they may not always work as effectively as they could. It keeps people's information safe and maintains the records it needs to by law. But information is sometimes missing which may mean that the pharmacy cannot always show what has happened in the event of a query.

Inspector's evidence

A set of standard operating procedures (SOPs) covered operational tasks in the pharmacy. The procedures had been updated by the pharmacy owner within the last two years but did not always routinely outline staff responsibilities. Team members had signed procedures as confirmation of their acknowledgement and understanding. But the procedures were not always fully implemented so the team might not always work effectively. The locum pharmacist reported that he had briefly read the procedures but had not signed as a record of this. Professional indemnity insurance covering pharmacy services was provided through the National Pharmacy Association (NPA). Team members had a general understanding of the activities which were permissible in the absence of a responsible pharmacist (RP).

Pharmacy team members recorded their near misses and incidents were discussed at the time they were identified. The regular pharmacist reviewed near misses periodically but a record of this was not necessarily kept, so team members may not always be able to show what they have learnt, and the team were unaware of any changes that had been made in response to previous reviews. The locum pharmacist discussed the actions that he would take in response to a dispensing incident and said that incidents would be reported to the superintendent pharmacist. This was in line with company SOPs.

The pharmacy had a complaint procedure, but this was not advertised so people may not always be aware how a concern could be raised. People using pharmacy services were able to provide feedback verbally, or via online reviews. The pharmacy also participated in an annual Community Pharmacy Patient Questionnaire (CPPQ) and previous results were positive.

The correct RP notice was conspicuously displayed near to the medicine counter. The RP log was maintained electronically but was not fully compliant as the time RP duties ceased was not always recorded. Private prescription and emergency supply records recorded details using dispensing labels, which may be removed or fade over time and compromise the integrity of the audit trail. Emergency supply records did not always record the nature of the emergency, so team members may not always be able to show what happened in the event of a query. Specials procurement records provided an audit trail from source to supply. Controlled Drugs (CD) registers were maintained in a paper format. There were occasional headings which were incomplete, so registers were not always maintained in keeping with regulations. The registers kept a running balance and some balance checks were carried out. Patient returned CDs were recorded and previous destructions were signed and witnessed.

The team had received some information on data protection and confidentiality and discussed how

people’s privacy would be protected in the pharmacy. But they had not read and signed all of the pharmacy's information governance procedures. They were unaware whether the pharmacy was registered with the Information Commissioner’s Office and a privacy notice was not seen on the day. The pharmacy layout was such that confidential information was not visible to the public, including on completed prescriptions which were stored out of view. Confidential waste was shredded on the premises and team members were in possession of their own NHS Smartcards, which they secured when not in use.

The pharmacy had a safeguarding procedure. Team members had not received any formal training, but a dispenser was able to discuss some of the types of concerns that might be identified and how these would be managed. Several examples were provided of actions that team members had taken where concerns regarding vulnerable people had been identified and the dispenser said that concerns were referred to the pharmacist or the GP.

Principle 2 - Staffing ✔ Standards met

Summary findings

There are enough staff to manage the current dispensing workload and team members are able to raise concerns and provide feedback on pharmacy services. But they do not get much regular training and feedback on their development. So, they may not always be able to show how they keep their knowledge up to date and make changes to improve their practice.

Inspector's evidence

On the day of the inspection, a locum pharmacist was working alongside a dispenser. The dispenser worked part-time two mornings each week in the pharmacy and was the manager of the post office for the remainder of the week. The dispenser was completing a dispensary assistant course through the NPA, but confirmation of this was not seen. A second dispenser was also employed and worked alongside the pharmacist at all other times. The dispenser was completing a customer services apprenticeship through a local college and had also been enrolled on a dispensary assistant course. She arrived at the end of the inspection to provide cover for the afternoon. The two dispensers arranged leave between themselves so that one of them was always available to provide cover. In the event of unplanned sickness, a dispenser reported that the owner had two other pharmacies nearby, who may be able to provide assistance if required. The workload was said to be manageable. The number of prescriptions being dispensed had increased in recent months. A dispenser said that this had led to the recruitment of the second dispenser and she had also changed her hours. The regular pharmacist was on planned leave and had been in post for approximately one year. Prior to this, the pharmacy had relied on locum cover for several weeks, following the departure of the previous manager.

During the inspection another employee was present, providing cover on the post office counter. The employee did not undertake any dispensing activities and was aware that she could not sell pharmacy restricted medicines. She was observed to direct patient requests for pharmacy restricted medicines to the pharmacist, who then asked appropriate questions to satisfy himself that the sale was safe and provided any appropriate advice. The pharmacist then directed the member of staff to take payement for the medicine through the till system. Although not directely involved in managing the sale or the provision of advice, the member of staff may benefit from some healthcare training.

The team were not provided with any structured ongoing training and development or protected training time. A dispenser said that she had attended training events on healthy living and smoking cessation but could not recall anything within the last year. There were no systems in place to review team development.

The team communicated using an encrypted messaging application and were happy to approach the regular pharmacist and owner on an ongoing basis with any concerns or feedback. The locum pharmacist had also previously provided feedback to the pharmacy manager. And the team discussed some changes which had been made within the last year, since the regular pharmacist had been in

employment. The team had signed to confirm acknowledgement of a whistleblowing policy in the SOP folder and they were unaware of any targets being in place for professional services, but a dispenser said that the owner encouraged services such as MURs.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is suitably maintained and has a consultation room to enable it to provide members of the public with an area for private and confidential discussions. But space in the dispensary is lacking. This impacts on overall organisation and may increase the likelihood of mistakes happening.

Inspector's evidence

The pharmacy is located inside a listed building which was in a reasonable state of repair. The owner was responsible for resolving any maintenance issues and daily cleaning duties were carried out by the pharmacy team. The ambient temperature appeared appropriate for the storage of medicines and a large portable fan was in place, to aid temperature regulation. There was adequate lighting throughout.

To the front of the premises was a retail space. There was one main service desk, which mainly serviced the post office. To the far side of the bench was a notice which prompted people to press a bell for attention from the pharmacy team. The pharmacy sold a range of health and beauty related items but also items relating to the postal business such as greeting cards and envelopes. Pharmacy restricted medicines were kept behind the counter to help prevent self-selection. The area was adequately sized and had a single chair available for use by people less able to stand. There were some parcels on one area of the floor, which may introduce a trip hazard. An enclosed consultation room was available off the retail area. The room was clearly signposted, appropriately maintained and contained a desk and seating to facilitate private and confidential discussions.

The dispensary was compact. There was limited work bench space available and some space was taken up by baskets of prescriptions which were owing items or were awaiting an accuracy check. There were several boxes which were stored on the floor, which could create a trip hazard for staff. A separate sink area was available for the preparation of medicines and was equipped with appropriate hand sanitiser. The pharmacy had additional storage areas to the first floor. The staircase was partially blocked by several bags of rubbish, and the storage areas appeared unorganised. The floor was also sunk in some areas; these factors may cause a health and safety risk.

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

Summary findings

The pharmacy's services are generally suitably managed, and they are accessible to most people. It gets medicines from reputable sources, but does not carry out enough checks to show that it stores medicines appropriately and make sure that they are suitable to supply.

Inspector's evidence

The pharmacy was accessed by three steps from the main street. The buildings listed status meant that a ramp facility could not be installed, and a portable ramp could not be used due to the angle of the street to the steps. A grab rail had been approved and installed to assist people with mobility issues and team members provided additional assistance as appropriate. The pharmacy had access to a hearing loop device and a dispenser believed that large print labels could be generated from the PMR system to assist people with visual impairment but was unsure as to how this would be done. The pharmacy's opening hours were displayed at the entrance to the premises but there was limited advertisement of its services and a practice leaflet was not available. The pharmacist had an awareness of some services in the local area and internet access was available to support signposting. Some health promotion literature was also displayed.

Baskets were used to separate prescriptions and reduce the risk of medicines being mixed up and audit trails for dispensing were maintained using 'dispensed' and 'checked' boxes on medicine labels. The team discussed the use of 'pharmacist' stickers which were used to identify any instance where the pharmacist wished to provide additional counselling or monitoring. Prescriptions for high-risk medications such as warfarin were not routinely highlighted, to ensure people were getting appropriate monitoring and counselling. The team were unaware of recent guidance regarding the supply of valproate-based medicines to people who may become pregnant. The inspector advised that the team reviewed the relevant information and obtained the necessary safety materials. The pharmacy highlighted some prescriptions for CDs, but a prescription for diazepam was seen not to be marked, which may increase the risk that a supply is made beyond the valid 28-day expiry date.

The pharmacy ordered medicines for people who received multi-compartment compliance aid packs. This included approximately 20 patients who lived in two local care home facilities. A dispenser kept a record of when packs were due, and the details of prescriptions sent off and received back from the GP surgery so that unreturned prescriptions could be identified. Master records of medicines were held for each patient. The records were updated with any changes to medicines. Some sheets had been amended numerous times and needed rewriting, so the details were clear. Completed packs had patient identifying details and descriptions of individual medicines were recorded on backing sheets. Patient leaflets were not supplied as they should be. So, people may not always have access to the information they need to take their medicines properly. The dispenser was aware of some medicines which were unsuitable for supply in a compliance aid pack. One pack which contained Epilim was assembled weekly to help manage stability issues and checks regarding stability were referred to the pharmacist. The pharmacy delivered medicines to people who were housebound. The team reported that signatures were obtained as confirmation of delivery, but records were unavailable on the day.

There were some deliveries which were posted through letterboxes. The team said that this was done at patient request and checks were carried out to help make sure that this was safe. But they did not keep a record of the risk assessments.

The pharmacy obtained stock medicines from reputable wholesalers and specials from a licensed manufacturer. There was a large amount of stock on the shelves, allowing for very little segregation between different strengths and formulations of medicines. There were several medicines which had been packed out of the original container into brown medicine bottles. In some instances, these were not labelled with a batch number or expiry date and they were removed from the shelves on the day. Team members carried out date checks periodically and highlighted short-dated medicines. A box of candesartan which expired in July 2019 was identified on the shelves and was removed. The box had been marked in line with pharmacy procedures. Expired and returned medicines were placed in medicine waste bins. Hazardous waste guidelines were displayed but a cytotoxic waste bin was not available to allow for these medicines to be segregated. The pharmacy was not yet compliant with the requirements of the European Falsified Medicines Directive (FMD) and some team members were unaware with the required changes. The pharmacy had recently received a new scanner, but this was not yet being used and team members were unable to provide a timeline for implementation. Alerts for the recall of faulty medicines and medical devices were received via email. The pharmacy had previously kept an audit trail of alerts received, but this had not been updated in recent months. The email system appeared to show that some recent alerts had not been read. The locum pharmacist opened these and the team agreed to review and action them on the day and maintain an audit trail moving forward.

CDs were stored appropriately with expired and returned CDs segregated from stock. CD denaturing kits were available for use. The pharmacy fridge was fitted with a maximum and minimum thermometer. The temperature was checked and recorded daily. Since 18 July 2019 the records showed that the fridge had been consistently outside of the recommended temperature range and the maximum temperature on the day read 10.5 degrees Celsius. There was no documentation to confirm the action that had been taken in response to this. But team members confirmed that the pharmacist was aware.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy's equipment is suitably maintained and it has the equipment it needs to provide its services.

Inspector's evidence

The pharmacy had access to some paper-based reference materials and internet access supported additional research. The equipment seen was reasonably well maintained. Glass measures were crown-stamped, or ISO approved, and separate measures were used with CDs. The pharmacy had counting triangles for loose tablets, but one needed cleaning as it contained left over tablet residue.

The layout of the pharmacy mean that computer screens were shielded from public view and a laptop computer was secured. Electrical equipment was in working order and systems were password protected. Team members used a cordless phone to enable conversations to take place in private, if required.

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.