General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Eye Pharmacy, 5 Broad Street, EYE, Suffolk, IP23 7AF

Pharmacy reference: 1037142

Type of pharmacy: Community

Date of inspection: 08/04/2019

Pharmacy context

The pharmacy is located on the main street in the rural village of Eye in Suffolk. It dispenses NHS prescriptions and also offers Medicines Use Reviews (MUR) and some New Medicine Service (NMS) consultations. The pharmacy supplies medicines in multi-compartment compliance packs to people in a local residential care home and it provides a flu vaccination service during the winter season.

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 not all met	1.1	Standard not met	The pharmacy does not have any standard operating procedures available on the premises.
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 cannot show that medicines which require refrigeration are stored at appropriate temperatures.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance **Standards not all met**

Summary findings

The pharmacy generally has safe and effective working practices but does not have any current standard operating procedures on the premises. So, team members and visiting pharmacists are not able to show that they are following current approved practice. The pharmacy manages risk appropriately by doing occasional reviews and it keeps people's private information safe. It asks people for their views. It keeps the records required by law to ensure that medicines are supplied safely and legally.

Inspector's evidence

The pharmacy kept near miss and error logs and these were reviewed annually. They agreed that a more regular review may identify some trends and patterns. But the pharmacy had a low level of near misses.

Following dispensing incidents, the mistake was discussed with the individual concerned on a one to one basis, with any learnings shared with the dispensary team. Team members were encouraged to identify their own errors and were comfortable about feeding back to the pharmacist. They talked about the no-blame culture in the pharmacy where mistakes were discussed to reduce future risk.

The pharmacy received positive feedback on the NHS website. They invited people to complete an annual survey and had a published complaints procedure. The pharmacy scored well on the most recent survey. The pharmacy had current professional indemnity insurance arrangements in place.

The pharmacy had the right Responsible Pharmacist (RP) notice on display and RP records were correctly completed. The dispenser said that roles and responsibilities were identified in the standard operating procedures (SOPs) but these were not available. When asked, members of the pharmacy team clearly understood what they could and couldn't do when the pharmacist was not present.

The owner said that the pharmacy had a comprehensive range of SOPs in place. But, these had been removed from the branch some months earlier to be updated and had not yet been returned. The dispenser said that she had read and signed the previous procedures and was able to give examples. But, it was not possible to compare the current practice with the approved procedures. The owner offered to forward a copy of the new procedures.

The records examined were maintained in accordance with legal and professional requirements. These included: the private prescription register (for private prescriptions and emergency supplies), records for the supplies of unlicensed medicines and the RP record. The controlled drug (CD) registers were appropriately maintained. CD balance checks were done each month. There was also a book where patient returned CDs were recorded.

The pharmacy had a cordless phone to facilitate private conversations and the correct NHS smartcards were in use. The patient medication record (PMR) was password protected and sensitive waste was

securely disposed of. Prescriptions were stored securely in the dispensary. The dispenser was unaware of any recent training or updates in relation to the General Data Protection Regulation and was not aware of confidentiality declarations being used in the pharmacy.

The pharmacy had safeguarding procedures in place and team members described the actions that would be taken in the event of a safeguarding concern. There were contact details for the local safeguarding team.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough team members to manage its workload safely. They are appropriately trained, and have a good understanding about their roles and responsibilities. The pharmacy does not have a regular pharmacist and the day to day running of the pharmacy is delegated to the full-time dispenser.

Inspector's evidence

The regular pharmacist had recently left and the company was struggling to recruit a permanent replacement. In the interim, the pharmacy relied on pharmacists from other branches within the company. There was one pharmacist on any given day. There were two trained dispensers (one full-time and one part-time). They were both counter trained.

The pharmacy team regularly read articles in pharmacy magazines and completed online learning modules to keep their knowledge and skills up to date. Ongoing learning was largely self-directed. There were no appraisals or performance reviews to support the team members in their learning and development.

The pharmacy team members were routinely encouraged to spot their own mistakes and were equally comfortable approaching the pharmacist in the same way. They described an open culture where the focus was learning rather than blame.

In the absence of a regular pharmacist the day to day running of the pharmacy was delegated to the full-time dispenser. She had a clear focus on keeping work stations clear and keeping up to date with routine tasks. Targets and incentives were in place but the pharmacist said that these did not impact on patient safety or professional judgement.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy team keeps the pharmacy secure, clean and tidy. The pharmacist has an area to check prescriptions and this is kept clear to help reduce the risk of mistakes.

Inspector's evidence

The pharmacy had carpeted floors throughout the shop area and vinyl in the dispensary. They had laminated worktops and a dedicated sink for the preparation of medicines. These were clean. There were clear workflows in place and a designated checking area. After the previous inspection, the pharmacy had improved workflows by increasing the amount of bench-space in the dispensary.

There was a clean, bright and well-maintained consultation room with a good level of soundproofing where patients could consult pharmacy team members in private. The other half of the room was used for assembling multi-compartment compliance packs. But, people were not left alone in the room and there was a portable screen to separate the two areas. People were escorted through the dispensary to the room and the pharmacy team were careful to make sure people could not see confidential information.

The pharmacy had good levels of lighting throughout. They were about to install thermometers to check room temperatures and make sure that stock was kept appropriately. The air conditioning unit was broken but the owner indicated that it was going to be replaced before the summer. The pharmacy premises were kept secure.

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

Summary findings

The pharmacy gets its medicines from reputable suppliers, and generally stores them properly. It takes the right action if any medicines or devices need to be returned to the suppliers.
The pharmacy team members identify and give advice to people taking high risk medicines to make sure that they are taken safely.The pharmacy cannot demonstrate that medicines requiring refrigeration have been stored at appropriate temperatures. This makes it harder to show that medicines are safe to use. The team members generally follow safe practice to assemble devices which help people to take their medication. But they do not always label multi-compartment compliance packs with the required warning information. And people are not always given the information leaflets which come with their medicines. So, they may not have all the information they need to help them take their medicines safely. The pharmacy team are working to address this.

Inspector's evidence

The pharmacy was accessed via a single wide door with a small step at path level. The pharmacy team had trained as Dementia Friends, and generated larger print labels for people with visual impairment.

The pharmacy obtained stock from a range of licenced wholesalers and it was stored in a neat and tidy manner in the dispensary. The dispenser said that stock was date checked twice a year. The records for this were not on the premises at the time of the inspection. No expired products were found on the shelves.

The pharmacy team were aware of the Falsified Medicines Directive and had signed a contract with a software provider to ensure the pharmacy achieved compliance. The system was not yet up and running. This made it harder for the pharmacy to show that it was fully complying with the current requirements around falsified medicines.

The pharmacy sometimes monitored patients on high risk medicines such as lithium, warfarin and methotrexate and the pharmacists routinely enquired about blood test results related to these medicines. Results were generally recorded on the patient medication records (PMR).

The pharmacy team were aware of the risks associated with dispensing valproate containing products and the Pregnancy Prevention Programme. The pharmacy had conducted an audit of all their patients who took valproate containing medication.

Medicines requiring cold storage were kept in a domestic fridge. The maximum and minimum temperature thermometer had recently broken and a replacement was on order. The pharmacy was using a thermometer that only recorded the current temperature in the interim, to ensure that stock was stored at an appropriate temperature. Records indicated that stock had been kept above 8 degrees Celsius since the start of February 2019. They noted that the thermometer was faulty. The electronic record would only allow an entry for the maximum and minimum temperature to be entered and it was not possible to use the temperature of the current thermometer. The pharmacy was not able to demonstrate that medicines had been stored at appropriate temperatures.

The pharmacy wrote on each controlled drug prescription to help ensure that medicines were not issued after the prescription had expired. It stored CDs securely.

The pharmacy team dispensed medication into multi-compartment compliance packs. These were disposable, tamper evident packs which had descriptions of the medication. The packs were not routinely supplied with patient information leaflets. The labelling sheets used on the packs did not always contain the additional warnings and information about how to take the medicine. The dispenser agreed to use the original dispensing labels in the packs until she could find out how to have the information added to the backing sheets. She agreed to supply patient information leaflets with each supply and not just on the first occasion.

A team member described the process they followed to ensure that any mid-cycle changes to the packs were rechecked to make sure that these were supplied safely. The pharmacy had record sheets to record any changes to medication in the packs and allow effective team communication. The GP requested when patients should receive their medication in multi-compartment compliance packs. The pharmacy team did not routinely use a risk assessment tool to check on the suitability of a compliance pack.

The pharmacists had undertaken anaphylaxis training. Pharmacy staff described a safe procedure for receiving needles into the pharmacy and had received training in needle-stick injury avoidance. Patient returns were clearly segregated into designated bins and disposed of appropriately. Drug alerts were received and recorded electronically in the pharmacy.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the right equipment for its services and makes sure that it is looked after properly. It uses this equipment to keep people's private information safe

Inspector's evidence

The pharmacy had up to date reference sources and testing equipment from reputable suppliers. It had stamped glass measures (with designated labelled measures for methadone) and labelled equipment for dispensing cytotoxic medication such as methotrexate.

The pharmacy had a new blood pressure monitor and this was replaced every two years. Fire extinguishers were serviced under an annual contract. All electrical equipment appeared to be in good working order and had been safety tested. The pharmacy stored sensitive records securely. The patient medication record was password protected and confidential waste was disposed of using a shredder.

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.