General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Claines Pharmacy, 153-155 Ombersley Road, WORCESTER, Worcestershire, WR3 7BX

Pharmacy reference: 1038905

Type of pharmacy: Community

Date of inspection: 02/05/2019

Pharmacy context

This is a community pharmacy in a residential area on the outskirts of the city of Worcester. Most people using the pharmacy are elderly. There are few other local shops in the area. The pharmacy dispenses NHS prescriptions, sells over-the-counter medicines and a variety of other items to meet the needs of the local population. The pharmacy supplies medicines in multi-compartment devices to help vulnerable people in their own homes to take their medicines. They also supply medicines to people in local care home.

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	N/A	N/A	N/A
2. Staff	Standards met	2.4	Good practice	The staff are encouraged to keep their skills up-to-date and they do this in work time. The team members who are undertaking training are well supported.
		2.5	Good practice	The pharmacy team are well supported by their manager. They are comfortable about providing feedback to him to improve services and this is acted on.
3. Premises	Standards met	N/A	N/A	N/A
4. Services, including medicines management	Standards met	4.2	Good practice	The pharmacy team make sure that people have the information that they need to use their medicines safely and effectively. They intervene if they are worried, think that they may not be using their medicines as prescribed by their doctors or are suffering from side-effects.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance ✔ Standards met

Summary findings

The pharmacy's working practices are safe and effective. The working area is small but the team manage this risk well. The pharmacy asks its customers for their views and they use the feedback to improve services. They keep the up-to-date records that they must do by law. The pharmacy is appropriately insured to protect people if things go wrong. The pharmacy team generally keeps people's private information safe and they know how to protect vulnerable people.

Inspector's evidence

The pharmacy staff identified and managed risks. There had been no errors at the pharmacy for a long time. But, any dispensing error or incident would be recorded, reviewed and appropriately managed. A full root cause analysis would be done. Near misses were recorded and included learning points and actions taken to reduce similar recurrences, such as, clearly separating the gabapentin 100mg from the 300mg and highlighting modified release preparations. Any learning or other issues were displayed on the communication board. Look alike, sound alike (LASA) drugs were highlighted to reduce the likelihood of picking errors with these.

The dispensary was small but the space was well organised. There was a main labelling area, an assembly area, a waiting to be checked area and a checking area. Because of the limited space, baskets of prescriptions waiting to be checked, were stored on top of one another. But, the pharmacist was aware of this risk and had only one basket at a time in the checking area. The pharmacy supplied medicines to a local care home and some domiciliary dosette boxes. These were only assembled during quiet periods and the person undertaking the task was not interrupted to reduce the risk of errors. There was a clear audit trail of the dispensing process and all the 'dispensed by and checked by' boxes on the labels examined had been initialled.

Up-to-date, signed and relevant Standard Operating Procedures (SOPs), including SOPs for services provided under patient group directions were in place and these were reviewed every two years, or sooner, if necessary, by the Superintendent Pharmacist. The roles and responsibilities were set out in the SOPs and the staff were clear about their roles.

The questions that staff should ask customers requesting to buy medicines were displayed on the till. A medicine counter assistant (MCA) trainee said that she would refer all requests for children under two to the pharmacist. She would also refer anything that she was uncertain of. The pharmacy team knew about 'prescription only medicine' (POM) to 'pharmacy only medicine' (P) switches, such as, Viagra Connect. They all knew that fluconazole capsules should not be sold to women over 60 for the treatment of vaginal thrush.

The staff were clear about the complaints procedure and reported that feedback on all concerns was encouraged. The pharmacy did an annual customer satisfaction survey. In the 2019 survey, 100% of customers who completed the questionnaire rated the pharmacy as excellent or very good overall. There had been some feedback about having somewhere private to talk. The consultation room was well signposted, but because of the feedback, the staff proactively offered the use of this room to

customers.

Public liability and indemnity insurance provided by the National Pharmacy Association (NPA) and valid until 31 March 20120 was in place. The Responsible Pharmacist log, controlled drug (CD) records, including patient-returns, private prescription records, emergency supply records, specials records, fridge temperature records and date checking records were all in order.

There was an information governance procedure and the staff had also recently completed training on the new data protection regulations. The dispensary computers, which were not visible to the customers, were password protected. But, there was a risk of a breach of patient confidentiality in the consultation room. A cupboard in here, where electronic prescriptions were stored, had clear glass panels and the details on the prescriptions could be seen. The pharmacist said that he would get the panes of glass frosted and get a lock for the cupboard. Patient-sensitive information was also stored on open shelves but this was contained in files. The pharmacist said that he would discuss with the Superintendent about installing locked cupboards for these. He did say that he did not leave anyone in the room on their own. The door from the dispensary into the consultation room contained a clear glass panel. The pharmacist gave assurances that this would be frosted. Confidential waste paper information was collected for appropriate disposal. No conversations could be overheard in the consultation room.

The staff understood safeguarding issues and had received training from the pharmacist. The pharmacist had completed the Centre for Pharmacy Postgraduate Education (CPPE) module on safeguarding. Local telephone numbers were available to escalate any concerns relating to both children and adults. All the staff had completed ‘Dementia Friends’ training.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough staff to manage their workload safely. And, the company provides help when people are on holiday or off sick. The staff are encouraged to keep their skills up-to-date and they do this in work time. The team members who are undertaking training are well supported. The pharmacy team are well supported by their manager. They are comfortable about providing feedback to him to improve services and this is acted on.

Inspector's evidence

The pharmacy was in a residential area on the outskirts of the city of Worcester. They dispensed approximately 5500 NHS prescription items each month with the majority of these being repeats. 32 domiciliary patients and 50 care home patients (nursing and residential) received their medicines in monitored dosage systems (MDS). Few private prescriptions were dispensed.

The current staffing profile was one pharmacist, one pre-registration student (not seen), one full-time NVQ2 trained dispenser, one part-time trained medicine counter assistant (MCA) and one part-time MCA trainee.

The two part-time MCAs were flexible and covered each other, both with planned and unplanned, absences. If the trained dispenser was ill or away on holiday, help was provided from one of the other branches (six in the company). Planned leave was booked well in advance and only one member of staff could be off at one time. A staffing rota was used to ensure appropriate staffing levels with the desired skill mix.

The staff clearly worked well together as a team and they knew their customers well. Staff performance was monitored, reviewed and discussed informally throughout the year. There was an annual performance appraisal where any learning needs could be identified. Review dates would be set to achieve this. The qualified dispenser had recently raised that she would like to do the technician training. Because of this, she was due to start the course in the next two weeks.

The pharmacist proactively provided training for his staff, such as, on safeguarding, the NPA training on the new data protection regulations, care home training and a recent CPPE module on child dental health. He had a training log for all his staff and they spent about 1 hour each month of protected time learning. The staff enrolled on accredited courses, such as the MCA course, were allocated additional time for learning. The pharmacist said that the dispenser, soon to start the technician's course, would be allocated specific learning time towards her course. The MCA trainee said that she was well supported by the pharmacist. The dispensary staff reported that they were supported to learn from errors. The pharmacist reported that all learning was documented on his continuing professional development (CPD) records.

The staff knew how to raise a concern and reported that this was encouraged and acted on. A qualified dispenser had recently raised issues with files taking up valuable space in the small dispensary. Because of this, the files had been moved to a more suitable position to allow the dispensing bench to be kept clear. There were bi-monthly staff meetings. All the staff were aware of the company's whistle-blowing policy.

The pharmacist reported that he was set overall targets, such as 400 annual medicine use reviews (MURs). He said that he only did clinically appropriate reviews and did not feel unduly pressured by the targets.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy looks professional. The work areas are small but tidy and organised. There is good signposting to the consultation room so it is clear to people that there is somewhere private for them to talk. But, the room is a difficult shape and so people cannot sit face-to-face. This may hinder some conversations.

Inspector's evidence

The pharmacy was well laid out and presented a professional image. The dispensing space was limited but it was organised and well utilised. The premises were clean and well maintained.

The consultation room was quite spacious and well signposted. But, it was a difficult shape. The table containing a lap top computer was placed against a wall and so it was difficult for people to sit face-to-face. This arrangement also meant that there was an increased possibility of the accidental disclosure of confidential information from the computer screen. It would be difficult to obscure the screen during a consultation. The pharmacist was aware of this risk. As mentioned under principle 1, some confidential information was not stored securely in here and the clear glass panel in the door also meant that patient confidentiality may be compromised. The pharmacist has given assurances that these issues will be addressed. Conversations in the consultation room could not be overheard. The telephone was cordless and all sensitive calls were taken in the consultation room or out of earshot.

There was air conditioning and the temperature in the pharmacy was below 25 degrees centigrade. There was good lighting throughout. Most items for sale were healthcare related.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy offers a good range of services. Most people can access these services. But, some people with specific mobility needs may have difficulty entering the pharmacy. The services are effectively managed to make sure that they are provided safely. The pharmacy team make sure that people have the information that they need to use their medicines safely and effectively. They intervene if they think that they may not be using their medicines as prescribed by their doctors or are suffering from side-effects. The pharmacy gets its medicines from appropriate resources. The medicines are stored and disposed of safely. The pharmacy team make sure that people only get medicines or devices that are safe.

Inspector's evidence

There was wheelchair access to the pharmacy and the consultation room but no bell on the front door to alert the pharmacy team to anyone who may need assistance. There was access to Google translate on the pharmacy computers for use by non-English speakers. The pharmacy could print large labels for sight-impaired patients.

Advanced and enhanced NHS services offered by the pharmacy were medicine use reviews (MURs), new medicine service (NMS), emergency hormonal contraception (EHC), supervised consumption of methadone and buprenorphine (but no current clients) and seasonal 'flu vaccinations. The latter was also provided under a private scheme, as were, travel vaccines and malaria prophylaxis. The services were well displayed and the staff were aware of the services offered.

The pharmacist had completed suitable training for the provision of vaccination services including face to face training on injection technique, needle stick injuries and anaphylaxis. He had also completed suitable training for the provision of the free NHS EHC service and for the provision of the private malaria prophylaxis service.

32 domiciliary patients received their medicines in monitored dosage systems (MDS) and 50 care home patients (nursing and residential) received medicines in original packs. The domiciliary dosettes were assembled each week (8 a week) on rolling basis and evenly distributed throughout the week to manage the workload. Due to the lack of space in the dispensary, they were only assembled when it was quiet. The person doing this task was not interrupted to reduce the risk of errors. Each patient had a dedicated poly-pocket where all the relevant information such as hospital discharge sheets and changes in dose were kept. These were referred to at the checking stage. None of the patients were prescribed high-risk medicines needing regular blood tests, such as warfarin and methotrexate.

The pharmacy also provided services to a local care home. The medicines were supplied in the original packaging. The home ordered their own prescriptions and the pharmacy sent copies of them to the home for checking. The home emailed the pharmacy with any queries. The pharmacy also kept a communication book to record any issues. The pharmacist visited the home every six months and looked at medicine's management. Because of the lack of space in the dispensary the assembly of the home prescriptions was done well in advance, two weeks. The person responsible for this was not interrupted to reduce the risk of errors. None of the patients were prescribed high-risk medicines requiring regular blood tests.

There was a good audit trail for all items ordered on behalf of patients by the pharmacy and for all items dispensed by the pharmacy. Interventions were seen to be recorded on the patient's prescription medication record. The pharmacist routinely counselled 'walk-in' patients prescribed high-risk drugs such as warfarin and lithium. INR levels were recorded. He also counselled patients prescribed amongst others, antibiotics, new drugs and any changes. CDs and insulin were checked with the patient on hand-out. All the staff were aware of the new sodium valproate guidance. One female patient of child-bearing age used the pharmacy. They gave her an information card with each prescription.

All prescriptions containing potential drug interactions, changes in dose or new drugs were highlighted to the pharmacist. Signatures were obtained indicating the safe delivery of all medicines and owing slips were used for any items owed to patients. Potential non-adherence or other issues were identified at labelling and ordering. Any patients giving rise to concerns were targeted for counselling. The pharmacist said that he frequently identified during MURs that patients did not know the correct timings to take their medicines. He also identified side effects, such as muscle ache from people taking statins. These patients were referred to their doctors and the medicine was changed.

Medicines and medical devices were obtained from AAH, Alliance Healthcare, Day Lewis and Lexon. Specials were obtained from Lexon Specials, IPS or PharmSpec. Invoices for all these suppliers were available. CDs were stored tidily in accordance with the regulations and access to the cabinet was appropriate. There were no patient-returned or out-of-date CDs. Appropriate destruction kits were on the premises. Fridge lines were correctly stored with electronic records. Date checking procedures were in place with signatures recording who had undertaken the task. Doop bins were available for waste and used and there was a cytotoxic bin and a list of substances that should be treated as hazardous for waste purposes.

There was a procedure for dealing with concerns about medicines and medical devices. Drug alerts received electronically, printed off and the stock checked. They were signed and dated by the person checking the alert. Any required actions were recorded. A separate audit sheet was also filled in. The pharmacy had received an alert on 7 February 2019 about amoxicillin 500mg capsules. The pharmacy had none in stock and this was recorded.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the appropriate equipment for the services it provides.

Inspector's evidence

The pharmacy used British Standard crown-stamped conical measures (10 - 100ml). There were tablet-counting triangles, one of which was kept specifically for cytotoxic substances. These were cleaned with each use. There were up-to-date reference books, including the British National Formulary (BNF) 76 and the 2017/2018 Children's BNF. There was access to the internet.

The fridge was in good working order and maximum/minimum temperatures were recorded daily. Doop bins were available and used and there was adequate storage for all other medicines. The dispensing areas were small but the space was well managed.

The pharmacy computers were password protected. There was a cordless telephone and any sensitive calls were taken in the consultation room or out of earshot. Confidential was information was collected for appropriate disposal. The door was always closed when the consultation room was in use and no conversations could be overheard.

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.