General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Nobles Chemist, 92 Savile Road, Savile Town, DEWSBURY, West Yorkshire, WF12 9LP

Pharmacy reference: 1039526

Type of pharmacy: Community

Date of inspection: 11/04/2019

Pharmacy context

This is a community pharmacy on a shopping parade with several other local shops. The pharmacy sells over-the-counter medicines and dispenses NHS prescriptions. It also dispenses private prescriptions. The pharmacy team offers advice to people about minor illnesses and long-term conditions. It also supplies medicines in multi-compartmental compliance packs to people living in their own homes.

Overall inspection outcome

Standards not all met

Required Action: Improvement Action Plan

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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 doesn't have any standard operating procedures (SOPs) available for the services it provides, including safeguarding the welfare of vulnerable people. So, the team members can't refer to them to ensure they provide services safely and effectively. The pharmacy has some local students working on occasions. So, it may be difficult for them to understand how to work in a consistent way.
		1.2	Standard not met	The pharmacy doesn't have a documented process to record near misses or dispensing errors. It doesn't have any forms available for the team members to complete. And it doesn't have any completed forms for the team to review. There is limited evidence of any actions taken following mistakes.
2. Staff	Standards met	N/A	N/A	N/A
3. Premises	Standards not all met	3.2	Standard not met	The pharmacy has a consultation room which allows people to have private conversations. But, people can see into the room and so people's dignity and privacy is not adequately protected.
4. Services, including medicines management	Standards not all met	4.3	Standard not met	The pharmacy doesn't have robust processes in place to manage its medicines. It doesn't make records of the checks it makes on expiry dates. And the equipment the pharmacy uses to check fridge temperatures does not work or is difficult to use. So, it can't be certain its medicines are always fit for purpose.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

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

Summary findings

The pharmacy doesn't have its written procedures readily available for the team to refer to. So, it can't evidence that the team works in a safe and effective way. The pharmacy advertises how people can provide feedback and raise concerns about its services. And it generally keeps people's private information safe. The team members are aware of the need to protect the welfare of vulnerable people, but the pharmacy doesn't have any information for the team to refer to. So, it may not always give the most up to date advice. The pharmacy doesn't have a structured system in place to help the team record mistakes and to learn from them. The pharmacy keeps most records it must by law.

Inspector's evidence

The dispensary had a manageable workflow with separate, areas for the team members to undertake the dispensing and checking parts of the dispensing process. Baskets were available to hold prescriptions and medicines, but they were not always used. So, there was a risk that medicines for different people may be mixed up.

It was reported that the pharmacy had a set of standard operating procedures (SOPs). But these were not available for inspection. The regular pharmacist advised that they had been taken away from the premises since the beginning of April 2019 to be reviewed. The SOPs were reviewed every two years. The SOPs were being reviewed by the superintendent pharmacist. And were due to be brought back to the pharmacy in May 2019. So, the team didn't have any written procedures to refer to in the meantime.

The team described the process that was in place to report and record errors that were made during the dispensing process. The pharmacist typically spotted the error and then made the team member aware of it. And then asked them to rectify it. The team recorded the details of these errors on to a paper log. But the log was not available to inspect. The team members advised the inspector that the log was also being reviewed along with the SOPs. The pharmacist recorded the details of any errors onto scrap pieces of paper while the log was absent. The information recorded would then be transferred on to the log when it returned to the pharmacy. But no examples were available to be inspected. The team members noticed that the most common error was selecting the wrong strength of lansoprazole. And that they had segregated two different strengths of lansoprazole on the dispensary shelves to reduce the number of selection errors. They did not demonstrate any other steps that had been put into place to reduce the risk of errors.

The team members said that they had a procedure in place to report and record details of any dispensing errors that had inadvertently been supplied to people. The procedure involved recording details of the incident onto a patient safety incident form. But the form was not available to be inspected. The team members advised such incidents were rare but could not provide any evidence to support this.

A procedure was in place to handle and report complaints from members of the public. The procedure

was displayed in the retail area however it was situated behind a retail display and was therefore difficult for people to see.

The pharmacy obtained feedback from people who used the pharmacy, through a community pharmacy questionnaire. The pharmacy did not display the results of the latest questionnaire. The team members said that they asked people to complete questionnaires over a period of a few weeks and then looked to see if there were recurring themes or patterns. The questionnaire was only run every two to three years. This was because many of the people who used the pharmacy could not read English. But no provisions were made to help these people to be able to give feedback to the team. The team members could not provide any examples of how they had acted on any feedback.

Appropriate professional indemnity insurance facilities were in place

The responsible pharmacist notice displayed the correct details of the responsible pharmacist on duty. Entries in the responsible pharmacist record complied with legal requirements.

A sample of controlled drug (CD) registers were looked at and were found to be in order including completed headers, and entries were being made in chronological order. Running balances were maintained, but there was limited evidence of regular auditing. Two controlled drug items were balance checked and verified with the running balance in the register (MST 5mg X 8 and Zomorph SR 30mg capsules X 24). A CD destruction register for patient returned medicines was not available for inspection. So, the pharmacy couldn't evidence people's returned CD medication had been destroyed properly. Records of private prescription supplies were appropriately maintained.

The team held records containing personal identifiable information in staff only areas of the pharmacy. Confidential waste was placed into a separate bin to avoid a mix up with general waste. The team advised that the confidential waste was collected periodically by the superintendent pharmacist who organised its destruction. But the pharmacist said that the waste was more than likely incinerated. This could not be confirmed either way. Prescription medication waiting to be collected was stored in a way that prevented people’s confidential information being seen by members of the public. And computer screens were adequately positioned to ensure confidential information wasn’t on view to the public. The computers were password protected.

The pharmacist had completed training on safeguarding the welfare of vulnerable adults and children. The pharmacy technician was aware of the SOP which she could reference if she wanted to know the steps to take to raise or escalate a concern. The SOP however was not available for inspection. The team members suggested that in the absence of the SOP they would use the internet for information on how to raise or escalate a potential concern.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy employs people with the right skills to undertake the tasks within their role. And the pharmacy team members complete ongoing learning.
The pharmacy supports team members to discuss their performance and identify learning needs. And they can generally raise professional concerns where necessary.

Inspector's evidence

The pharmacy was staffed on the day of the inspection by the regular pharmacist, who was also a company director, a full-time pharmacy technician and a college student who only completed some basic tasks such as cleaning and organising stock in the retail area. The pharmacy was typically staffed by the regular pharmacist and the technician. But the student and some local pharmacy undergraduates occasionally worked when requested to do so. And, there was no evidence that they had completed any training on how to perform the tasks they were asked to do. The pharmacist organised the rotas and students would cover when the technician was absent. The superintendent pharmacist would cover when the regular pharmacist was absent.

The pharmacist supervised the technician. And she involved pharmacist in offering advice to people who were purchasing over-the-counter products for various minor ailments. They carried out tasks and managed their workload in a competent manner. And they asked appropriate questions when selling medicines that could only be sold under the supervision of a pharmacist. The team was aware of what could and could not happen in the pharmacists' absence.

The pharmacy technician advised that she had time during the working day to organise her continuing professional development and to learn about new over-the-counter products or the uses of prescription only medicines. The technician felt that she was well supported by the pharmacist. And she could ask the pharmacist questions openly about various healthcare conditions as they worked so closely together.

The technician received a formal performance appraisal every year. The appraisal was in the form of a one-to-one conversation with either the regular pharmacist or the superintendent pharmacist. The technician was given the opportunity to discuss various aspects of their performance, including what they had done well, what could be improved, and any learning needs they had identified. The appraisal was also an opportunity for team members to provide feedback on the processes and procedures of the pharmacy and suggests ways to improve. But no examples were provided. The technician had recently asked for additional help with using the electronic prescription service software. And the technician received a one-to-one training session with the pharmacist to help her achieve her goal.

The team members described how they would raise professional concerns. Their explanations gave a clear understanding of how they would protect against professional risk and who they would raise their concerns with starting with their pharmacist and then escalating to the superintendent pharmacist. A whistleblowing policy was not in place. So, the team members may find it difficult to raise a concern anonymously.

The team was not set any performance related targets.

Principle 3 - Premises **Standards not all met**

Summary findings

The pharmacy is secure and is adequately maintained. It has a consultation room which allows people to have private conversations. But, people can see into the room and so people's privacy and dignity is not adequately protected.

Inspector's evidence

The pharmacy appeared dated, but was generally clean, hygienic and well maintained. Floor spaces were clear with no trip hazards evident.

There was clean, well maintained sink in the dispensary used for medicines preparation and staff use. There was a WC which provided a sink with hot and cold running water and other facilities for hand washing. The area was free of clutter.

The pharmacy had a signposted and sound proofed consultation room which contained adequate seating facilities. The room was smart and professional in appearance. The door of the room contained a transparent window. The view into the room from the retail area was only slightly restricted by a poster which had been affixed to the middle of the window. And so, people could see into the room while it was in use.

A stock room to the side of the dispensary was accessible via an internal door and an entrance from the street. The external door was kept locked during the inspection. The layout of the premises and the presence of staff restricted access to various areas of the pharmacy during opening hours

Temperature was comfortable throughout inspection. Lighting was bright throughout the premises.

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

Summary findings

The pharmacy provides a range of services that can help people to meet their health needs. But the pharmacy is not readily accessible to people using wheelchairs. And it doesn't have robust processes in place to ensure the medicines they supply to people are fit for purpose.

The pharmacy team identifies some risks associated with its services such as dispensing. And it generally manages the risk. But it doesn't supply leaflets to people taking some high-risk medicines. So, they may not receive all the information they need to help them take their medicines safely.

Inspector's evidence

The pharmacy could be accessed from the street, via a step, which led to a push/pull door. A ramp was not available. So, wheelchair users could not easily access the premises. A notice was affixed to a wall next to the entrance door. The notice outlined to people that wheelchair users could ring a bell for assistance. But there was no bell available. The services on offer, and opening times were advertised in the front window. Seating was provided for people waiting for prescriptions. Large print labels were provided on request. The team members had access to the internet. Which they used to signpost people requiring a service that the team did not offer.

Written notes were used on prescription bags to alert the team to issues on hand out. For example, interactions or the presence of a fridge or a controlled drug that needed to be added to the bag. An audit trail was in place for dispensed medication using dispensed by and checked by signatures on labels. A procedure was not in place to highlight dispensed controlled drugs, that did not require safe custody. And so, there was a risk that the medicine could be supplied to people after the prescription had expired.

The team members identified people who were prescribed high-risk medication such as warfarin. And they were given additional verbal counselling by the pharmacist. But details of these conversations were not recorded on people's medication records. So, the pharmacy could not demonstrate how often these checks took place. INR levels were not always assessed. The team were aware of the pregnancy prevention programme for people who were prescribed valproate. The team members were aware of the risks. And they demonstrated the advice they would give people in a hypothetical situation. The team did not have access to any literature about the programme that it could provide to people.

People could request multi-compartmental compliance packs. The team was responsible for ordering the person's prescription. And then the prescription was cross-referenced with a master sheet to ensure it was accurate. The team queried any discrepancies with the person's prescriber. The team recorded details of any changes, such as dosage increases/decreases, on the master sheets. The details of the prescriber authorising the change were not recorded. The team supplied the packs with backing sheets which contained dispensing labels. But it did not provide people with descriptions of the medicines contained in the packs. And so, people may struggle to visually identify the medicines if they needed to do so. The team supplied patient information leaflets to people each month.

The team were unsure if an audit trail for the delivery of medicines from the pharmacy to people was in

place. The pharmacy did not have a SOP available to check the agreed process. A note was posted to people when a delivery could not be completed, to advise them to contact the pharmacy.

There were occasions where the team could only provide people with a part-supply of their medicines due to stock availability. But people were not provided with a written record of this. So, the team may find it difficult to resolve any discrepancies. The pharmacy did not have a SOP available to check the agreed process.

Medicines that can only be sold in a pharmacy, and under the supervision of a pharmacist, were stored behind the retail counter. This prevented people from self-selecting these medicines.

The team checked the expiry date of stock every six to twelve months, but it did not keep any records of the activity. The team members were not sure when the last check was completed. They removed any stock that was due to expire in the next month. And reported that they used stickers to highlight stock that was due to expire in the next three months. But no evidence was seen. A random check of the dispensary stock found a pack of Nystaform HC cream which had expired in February 2019. The date of opening was not recorded on liquid medication that had a short-shelf life once opened.

The team members were not currently scanning products or undertaking manual checks of tamper evident seals on packs, as required under the Falsified Medicines Directive (FMD). No software, scanners or an SOP were available to assist the team to comply with the directive. The team had not received any training on how to follow the directive.

A controlled drug cabinet was in place and secure. The fridge used to store medicines was of an appropriate size. Medicines were organised in an orderly manner. Fridge temperatures were recorded daily using a digital thermometer. But the thermometer did not always work. The team used an analogue thermometer when the digital thermometer did not work. The analogue thermometer appeared old and difficult to use to accurately determine the temperature range.

The pharmacy obtained medicines from several reputable sources. Drug alerts were received via email to the pharmacy and actioned immediately. The alerts were printed and stored in a folder. The team did not record the action taken following a recall. So, it couldn't evidence that appropriate action had been taken.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The equipment and facilities the pharmacy uses in the delivery of services are clean, safe and protect people's confidentiality.

Inspector's evidence

References sources were available. And the team had access to the internet as an additional resource. The resources included a British National Formulary (BNF) and the BNF for Children. But they were not current issues.

The pharmacy used a range of CE quality marked measuring cylinders. Tweezers and rollers were available to assist in the dispensing of multi-compartmental compliance packs.

The computers were password protected and access to peoples' records were restricted by the NHS smart card system. Cordless phones assisted in undertaking confidential conversations.

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.