General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Burlington Road Pharmacy, 7 Burlington Road, BUXTON, Derbyshire, SK17 9AY

Pharmacy reference: 1073138

Type of pharmacy: Community

Date of inspection: 29/11/2019

Pharmacy context

This is a busy community pharmacy located in a residential area next to a medical centre. Most people who use the pharmacy are from the local area. The pharmacy dispenses mainly NHS prescriptions and sells a range of over-the-counter medicines. It supplies a large number of medicines in multi-compartment compliance aid packs to help people take their medicines at the right time. It does not have a private consultation room which limits the services which the pharmacy is able to offer.

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	4.2	Standard not met	The pharmacy assembles and checks multi-compartment compliance aid packs before the prescription has been received and stores them unlabelled and unsealed for extended periods.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance ✔ Standards met

Summary findings

The pharmacy generally manages risks to make sure its services are safe and takes some action to improve patient safety. It completes the records that it needs to by law and asks its customers for their views and feedback. The team has written procedures on keeping people's private information safe and team members understand how they can help to protect the welfare of vulnerable people.

Inspector's evidence

The pharmacy had standard operating procedures (SOPs) for the services provided but they had not been signed by the current members of the pharmacy team to show they had read and accepted them. However, one of the dispensers confirmed that she had read the SOPs even though she had not signed them. Some SOPs had not been reviewed for several years and did not reflect current practice. For example, the SOPs for multi-compartment compliance aid packs. Roles and responsibilities were set out in SOPs and the pharmacy team members were performing duties which were in line with their role. Team members wore uniforms but nothing to indicate their role, so this might not be clear to people. The name of the responsible pharmacist (RP) was displayed as per the RP regulations.

There was a SOP for recording labelling and dispensing errors. A root cause analysis was required to be completed following errors that left the pharmacy. The pharmacist superintendent (SI) worked as the regular pharmacist. He said there had not been any errors that he was aware of since taking over as SI, so there were no records available. Some near misses had been recorded and the SI said he reviewed these and discussed them with the pharmacy team. A dispenser said she was comfortable admitting and discussing errors and felt that learning from mistakes was encouraged. These reviews and discussions were not documented although a patient safety review was completed annually . Following a near miss when pantoprazole and paroxetine had been confused, the recorded action to prevent a re-occurrence was to highlight the medicines with alert stickers, however this had not happened yet. 'Double check ' alert stickers were in front of some look-alike and sound-alike drugs (LASAs) so extra care would be taken when selecting these. For example, carbimazole and carbamazepine. Clear plastic bags were used for assembled CDs and insulin to allow an additional check at hand out.

A dispenser described how she would deal with a customer complaint which was to refer it to the SI. There was a 'Dealing with complaints' SOP and the details of who to complain to was outlined in the practice leaflet. A customer satisfaction survey was carried out annually. The results from the most recent survey were on display and available on www.NHS.uk website. The areas of strength were 'staff overall'. An area identified which required improvement was providing advice on healthy eating, but the pharmacy had not published a response to this.

Insurance arrangements were in place. A current certificate of professional indemnity insurance was on display in the pharmacy. Private prescription records and the controlled drug (CD) register were appropriately maintained. Records of CD running balances were kept and these were regularly audited. Three CD balances were checked and found to be correct. Patient returned CDs were recorded and disposed of appropriately. The RP record was maintained electronically. The SI did not record an

absence when he left the premises to use a consultation room in the medical centre. He said this was because he had not considered it an absence but confirmed he would start to record these. A dispenser was clear that when the RP was in the medical centre he was not considered to be on the pharmacy premises, and would not sell a pharmacy medicine or supply a prescription, and she would wait for him to return, before she did so.

There was an information governance (IG) file which included information about confidentiality and a workbook on the General Data Protection Regulation (GDPR). The SI had completed some of it. A template was available for the pharmacy's privacy notice but it was incomplete. A statement that the pharmacy complied with the General Data Protection Regulation and the NHS Code of Confidentiality was given in the practice leaflet. Confidential waste was collected in a designated place and incinerated by one of the pharmacy's owners. A dispenser correctly described the difference between confidential and general waste. Assembled prescriptions awaiting collection were not visible from the medicines counter. Consent was received when Summary Care Records (SCR) were accessed.

The SI had completed the Centre for Pharmacy Postgraduate Education (CPPE) level 2 training on safeguarding. The dispensers had covered safeguarding as part of their dispensing training courses. There was some safe guarding guidance in the signposting file and the contact numbers of who to report concerns to in the local area. One of the dispensers had a good understanding of what signs to look out for and said she would voice any concerns regarding children and vulnerable adults to the pharmacist. All members of the pharmacy team had completed Dementia Friends training, so had a better understanding of patients living with this condition.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy team members receive training for the jobs they do. The team members are comfortable providing feedback to their manager and receive feedback about their own performance. But, ongoing training does not happen regularly and is not recorded, so their knowledge may not be always fully up to date.

Inspector's evidence

The SI was working as the responsible pharmacist and there were two NVQ2 qualified dispensers (or equivalent), and an apprentice dispenser on duty at the time of the inspection. The staffing level was adequate for the volume of work and the team were observed working collaboratively with each other and the patients. There was flexibility within the pharmacy team and absences were covered by re-arranging the staff hours or transferring staff from the neighbouring pharmacy. The SI worked most days in the pharmacy and was the pharmacy's manager.

Members of the pharmacy team carrying out services had completed appropriate training but there was no structured ongoing training once their training courses had been completed. Two of the team had completed their dispensing assistant courses this year and the apprentice dispenser was close to finishing her course. There was no other recorded training and team members were not given regular protected training time once they had finished their courses. The SI worked closely with the SI from the neighbouring pharmacy and had a peer review discussion with him as part of his GPhC revalidation.

The pharmacy team were given formal appraisals where performance and development were discussed and were given positive and negative feedback informally by the SI. Other issues were discussed on a daily basis as they arose and concerns could be raised. A dispenser said she felt there was an open and honest culture in the pharmacy and said she would feel comfortable talking to the SI or one of the pharmacy's owners about any concerns she might have. She said the staff could make suggestions or criticisms informally. She thought there was probably a whistleblowing policy but had not seen it and hadn't needed to use it.

The SI said he felt empowered to exercise his professional judgement and could comply with his professional and legal obligations. For example, refusing to sell a pharmacy medicine containing codeine because he felt it was inappropriate. He said targets were set by the pharmacy's owners, to maintain a certain level of NHS items and obtain pharmacy quality payments. But targets were not set for specific service such as Medicines Use Reviews (MURs) and New Medicine Service (NMS) and he did not feel under pressure to compete these. He had explained to the owners that the lack of a consultation room on the premises meant it was difficult to carry out many additional services, so they were aware of this limiting factor.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises generally provide a professional environment for people to receive healthcare. The pharmacy does not have a private consultation room, so members of the public cannot always have confidential conversations. And this limits the services which the pharmacy is able to offer.

Inspector's evidence

The pharmacy premises including the shop front and facia were reasonably clean and in an adequate state of repair. The retail area was free from obstructions, professional in appearance and had a waiting area with two chairs. The temperature and lighting were adequately controlled. Internal maintenance problems were dealt with by the SI who had a list of local contractors who could be contacted such as electricians and plumbers . External maintenance issues were reported to the practice manager at the medical centre, and the response time was appropriate to the nature of the issue.

The pharmacy used locked cupboards in the medical centre for extra storage and only the pharmacy team had access to these. The pharmacy team used the staff facilities in the medical centre which included a kitchen area and WCs with wash hand basins and hand wash. There was a separate dispensary sink for medicines preparation with hot and cold running water. Hand washing notices were displayed above the sink. There was no consultation room on the premises. The SI explained he used one of the nurse’s room, in the neighbouring medical centre if a private area was required to talk. On one afternoon a month the medical centre was closed for training so it was possible to book a nurse’s room for the whole afternoon and he could carry out MURs at this time.

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

Summary findings

The pharmacy offers a small range of healthcare services and they are generally well managed. However, it does not prepare, label and store multi-compartment devices appropriately and this increases the risk of contamination and errors. The pharmacy sources and supplies medicines safely. And it carries out appropriate checks to ensure medicines are in good condition and suitable to supply.

Inspector's evidence

The pharmacy was accessible to all, including patients with mobility difficulties and wheelchair users. Services provided by the pharmacy were displayed in the window of the pharmacy along with the opening hours and they were listed in the practice leaflet. There was a range of healthcare leaflets and some posters advertising local services. For example, Derbyshire sexual health. There was lots of information available in the waiting area from the British heart foundation which people could read whilst waiting for their prescriptions. The pharmacy team were clear what services were offered and where to signpost to a service not offered. For example, emergency hormonal contraception (EHC). A folder was available containing relevant signposting information which could be used to inform patients of services and support available elsewhere. Providing healthy living advice and signposting was not usually recorded, although the SI said he sometimes made a note on the patient's medication record (PMR) if they were a regular patient at the pharmacy. An audit of patients with diabetes was being carried out; 10 to 15 people had been referred for foot or retinopathy eye tests after it was identified that they had not been tested within the last year. Large print was available on dispensing labels and this facility was used by some partially sighted patients.

The pharmacy offered a repeat prescription ordering service and patients indicated their requirements in advance when they collected their medication. Requirements were checked again at hand-out and any unwanted medicines were retained in the pharmacy and the prescription endorsed as not dispensed. This was to reduce stockpiling and medicine wastage. There was a home delivery service with associated audit trail. Each delivery was recorded, and a signature was obtained from the recipient. A note was left if nobody was available to receive the delivery and the medicine was returned to the pharmacy.

Space was very limited in the dispensary, but the work flow was organised into separate areas with a designated checking area. Some of the dispensary shelves were very full and not very neat and tidy, risking picking errors when selecting medicines. Dispensed by and checked by boxes were initialled on the medication labels to provide an audit trail. Different coloured baskets were used to improve the organisation in the dispensary and prevent prescriptions becoming mixed up. The baskets were stacked to make more bench space available.

Stickers were put on assembled prescription bags to indicate when a fridge line or CD was prescribed. 'Speak to Pharmacist' stickers were used to highlight counselling was required and high-risk medicines such as warfarin, lithium and methotrexate were targeted for extra checks and counselling. INR levels were requested and recorded when dispensing warfarin prescriptions. The team were aware of the valproate pregnancy prevention programme. An audit had been carried out and one patient in the at-risk group had been identified. The SI had counselled her about pregnancy prevention. The valproate

care cards were not available but the SI said most packs now contained the relevant information and he said he would print the information from the Sanofi website if needed to ensure people in the at-risk group were given the appropriate information and counselling.

Around 80 patients received their medication in multi-compartment compliance aid packs but they were not always assembled and checked in line with the SOP. The packs were sometimes assembled in advance of a prescription, either using details from a previous prescription or from the patient's record card. The SI explained this was because the pharmacy did not receive the prescriptions from the medical practice in good time. These packs were not labelled and checked until the correct prescription had been received. But this could be up to a week later. They were stored unsealed and without appropriately labelling during this time, which breached labelling regulations and increased the risk of contamination and error. The pharmacist used the empty foil strip to carry out the accuracy check rather than the original packaging which further increased the risk of errors. Some of the patient record cards contained crossing out and alterations without explanation. There was no audit trail for communications with GPs and changes to medication. So, it was not always clear who had confirmed the changes and the date the changes had been made, which could cause confusion in the event of a query. Medicine identification was not completed to enable identification of the individual medicines and packaging leaflets were not usually included, despite this being a mandatory requirement. So patients and carers might not have easy access to information they need. The SI confirmed he would carry out a review of the procedure and liaise with the medical centre to ensure prescriptions for compliance aid packs were received in time, so the pharmacy could ensure the packs were assembled and checked safely. There was a SOP which included an assessment to see which adjustment was the most appropriate for a patient before supplying their medicines in a compliance pack, but the pharmacy did not complete this for patients requesting their medication in compliance packs. The SI said he assumed the GP or nurse carried out an assessment before referring people for this service.

A dispenser knew what questions to ask when making a medicine sale and when to refer the patient to a pharmacist. She was clear which medicines could be sold in the presence and absence of a pharmacist and understood what action to take if she suspected a customer might be abusing medicines such as a codeine containing product.

CDs were stored in two CD cabinets which were securely fixed to the wall. The keys were under the control of the responsible pharmacist during the day and stored securely overnight. Date expired, and patient returned CDs were segregated and stored securely. Patient returned CDs were destroyed using denaturing kits. Pharmacy medicines were stored behind the medicine counter so that sales could be controlled. Recognised licensed wholesalers were used to obtain medicines and appropriate records were maintained for medicines ordered from unlicensed 'Specials'. No extemporaneous dispensing was carried out.

The pharmacy was not compliant with the Falsified Medicines Directive (FMD) and was waiting for a decision on Brexit before fully committing, in case it was not necessary. It was registered with SercurMed but did not have the software or hardware needed to comply so the team were not able to scan to verify or decommission medicines. The dispensary computer was being upgraded in the next few weeks and should contain the software required for FMD .

Medicines were generally stored in their original containers at an appropriate temperature. Date checking was carried out and documented. Short dated stock was highlighted. Dates had been added to opened liquids with limited stability. Expired medicines were segregated and placed in designated bins. Around twenty pots of loose tablets and capsules were stored without appropriate labelling and expiry dates. A dispenser said these had been popped out for use in compliance aid packs and then found not

to be needed. The foil strip they had been popped out of had been attached to the bottle so members of the pharmacy team could check the expiry date, but this was not in line with labelling regulations and might cause a problem if the foil strip became detached from the bottle.

Alerts and recalls were received via e-mail messages from the NHS. The SI said there were sometimes delays before these were received and he usually received notification of recalls first from the Royal Pharmaceutical Society (RPS). The SI described the action taken when they received the most recent recall which they had stock of. It was for some batches of ranitidine. The team had returned the affected stock but had not made a record of the action taken, so might not be able to respond to queries and provide assurance that the appropriate action had been taken.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

Members of the pharmacy team have the equipment and facilities they need for the services they provide. They maintain the equipment so that it is safe and use it in a way that protects privacy.

Inspector's evidence

Current versions of the British National Formulary (BNF) and BNF for children were available and the pharmacist could access the internet for the most up-to-date information. There was a clean medical fridge. The minimum and maximum temperatures were being recorded regularly and had been within range throughout the month. All electrical equipment appeared to be in good working order and had been PAT tested. There was a selection of clean glass liquid measures with British standard and crown marks. The pharmacy had a range of clean equipment for counting loose tablets and capsules, with a separately marked tablet triangle that was used for cytotoxic drugs. Medicine containers were appropriately capped to prevent contamination.

Computer screens were positioned so that they weren't visible from the public areas of the pharmacy. PMRs were password protected. Individual electronic prescriptions service (EPS) smart cards were used appropriately. Cordless phones were available in the pharmacy, so staff could move to a private area if the phone call warranted 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.