General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: J England Pharmacy Ltd, 280 Gidlow Lane, WIGAN, Lancashire, WN6 7PG

Pharmacy reference: 1075713

Type of pharmacy: Community

Date of inspection: 18/10/2019

Pharmacy context

This is a community pharmacy attached to a medical centre. It is situated in a residential area in Wigan. The pharmacy dispenses NHS prescriptions, private prescriptions and sells over-the-counter medicines. It also provides a minor ailment service. A number of people receive their medicines in multi-compartment compliance aids.

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	N/A	N/A	N/A
3. Premises	Standards met	N/A	N/A	N/A
4. Services, including medicines management	Standards met	N/A	N/A	N/A
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance ✔ Standards met

Summary findings

Members of the pharmacy team follow written procedures to help them work effectively. But the procedures have not been updated for several years, so they may not always reflect current practice. The pharmacy keeps the records it needs to by law. But members of the team do not always record things that go wrong, so they may miss some learning opportunities.

Inspector's evidence

There was a set of standard operating procedures (SOPs) which were issued in 2014. Some members of the pharmacy team had not signed to say they had read and accepted the SOPs. So they may not always understand what is expected of them or where responsibilities lies.

Dispensing errors were recorded by the superintendent (SI) on letterheaded paper. The information recorded contained an overview of the error but did not contain details of possible contributing factors. The most recent record involved the supply of medicines to an incorrect patient. The SI had discussed the error with the pharmacy team. A more recent error was known to have occurred but had not been recorded. Near miss incidents were recorded in a book. Few records were available, and the SI admitted it was likely that some incidents had not been recorded. He said mistakes would be highlighted to staff and the person responsible would be asked to rectify their own error. He provided examples of action that had been taken following near miss incidents. This included placing an alert on a patient's PMR about infrequently dispensed medicines.

Roles and responsibilities of the pharmacy team were described in individual SOPs. A counter assistant was able to describe what her responsibilities were and was clear about the tasks which could or could not be conducted during the absence of a pharmacist. The responsible pharmacist (RP) notice was displayed prominently. The pharmacy had a complaints procedure. This was described in the practice leaflet and it advised people they could give feedback to members of the pharmacy team. Any complaints would be recorded and followed up by the SI. A current certificate of professional indemnity insurance was on display in the pharmacy.

Records for the RP, private prescriptions and unlicensed specials appeared to be in order. Controlled drugs (CDs) registers were maintained with running balances recorded and checked monthly. Two random balances were checked, and both found to be accurate. Patient returned CDs were recorded in a separate register.

An information governance (IG) policy was available. Members of the pharmacy team were not aware of the policy and said they did not recall signing a confidentiality agreement. But, when questioned, they were able to describe how they would segregate confidential waste for it to be destroyed by an on-site shredder. There was no privacy notice on display. So people may not always be fully informed about how the pharmacy handles their information.

There was no safeguarding procedure available for the pharmacy team to refer to. The registered staff had completed level 2 safeguarding training. Contact details of the local safeguarding board were available. During the inspection, there was a situation outside the pharmacy which involved a vulnerable adult. The pharmacy team brought her into the consultation room and contacted the police

because they were concerned about her safety.

Principle 2 - Staffing ✔ Standards met

Summary findings

There are enough staff to manage the pharmacy's workload. Members of the pharmacy team are appropriately trained for the jobs they do. And they complete some additional training to help them keep their knowledge up to date.

Inspector's evidence

The pharmacy team included a pharmacist – who was the superintendent, two pharmacy technicians – one of whom was trained as an accuracy checker (ACT), six dispensers and two medicine counter assistants (MCA). A trainee MCA had recently commenced work within the last four weeks. The normal staffing level was a pharmacist, ACT, five dispensers and two MCAs. The volume of work appeared to be managed. Staffing levels were maintained by part-time staff and a staggered holiday system. The SI and a locum pharmacist were present at the time of inspection.

Members of the pharmacy team were provided with access to e-learning packages. They contained various training topics about pharmacy services and products. The pharmacy team said they would complete training when they could, and they had completed two or three topics in the last 12-18 months. Completion of training packages was not compulsory. So learning needs may not always be addressed.

The MCA gave examples of how she would sell a pharmacy only medicine using the WWHAM questioning technique, refuse co-codamol sales she felt were inappropriate and refer people to the pharmacist if needed. The locum pharmacist said she felt able to exercise her professional judgement and this was respected by the pharmacy team and SI. The dispenser said she received a good level of support from the pharmacy team and felt able to ask for further help if she needed it. There was no appraisal programme provided to the pharmacy team. So development needs may not always be fully identified or addressed. Staff said that they would be comfortable reporting any whistleblowing concerns to the SI. The locum pharmacist said she was not set any targets by the pharmacy.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are suitable for the services provided. A consultation room is available to enable private conversations.

Inspector's evidence

The pharmacy was clean and tidy, and appeared adequately maintained. The size of the dispensary was sufficient for the workload. A sink was available within the dispensary. Customers were not able to view any patient sensitive information due to the position of the dispensary and access was restricted by the position of the counter. The temperature was controlled by the use of air conditioning units. Lighting was sufficient. The staff had access to a kettle, separate staff fridge, and WC facilities.

A consultation room was available with access restricted by use of a lock. The space was generally clutter free with a computer, desk, seating, adequate lighting, and a wash basin. The patient entrance to the consultation room was clearly signposted and a chaperone policy was on display.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's services are easy to access, and they are generally well managed. But the pharmacy team does not always know when people are receiving higher-risk medicines. So it might not always check that the medicines are still suitable, or give people advice about taking them. The pharmacy team carries out some checks to make sure medicines are in good condition. But it does not always keep records, so it can't show that the checks have been done properly.

Inspector's evidence

Access to the pharmacy was level via a single door and was suitable for wheelchair users. There was also wheelchair access to the consultation room. Pharmacy practice leaflets gave information about the services offered. Pharmacy staff were able to list and explain the services provided by the pharmacy. If the pharmacy did not provide a particular service staff were able to refer patients elsewhere using a signposting folder. A range of leaflets provided information about various healthcare topics.

The pharmacy had a delivery service. Deliveries were segregated after their accuracy check and a delivery record was kept. Unsuccessful deliveries would be returned to the pharmacy and a card posted through the letterbox indicating the pharmacy had attempted a delivery. Deliveries of CD medicines were recorded in a separate book and a signature was obtained to confirm receipt.

The pharmacy team initialled dispensed by and checked by boxes on dispensing labels to provide an audit trail. They generally used dispensing baskets to separate individual patients' prescriptions to avoid items being mixed up. Owing slips were in use to provide an audit trail if the full quantity could not be immediately supplied. The ACT carried out the final accuracy check for some dispensed medicines. This included medicines that were repeated without any changes to the prescription. The pharmacist completed a clinical check when medicines were first dispensed by the pharmacy. But this was not repeated unless there was a change to the prescription. So there is a risk some important information may be overlooked.

Dispensed medicines awaiting collection were kept on a collection shelf using an alphabetical retrieval system. Prescription forms were retained, and stickers were used to clearly identify when fridge or CD safe storage items needed to be added. Staff were seen to confirm the patient's name and address when medicines were handed out.

Schedule 3 and 4 CDs were not highlighted, so there was a risk that they could be supplied after the prescription had expired. High-risk medicines (such as warfarin, lithium and methotrexate) were also not routinely highlighted. So the pharmacy team may not be aware when they are being handed out in order to check that the supply is suitable for the patient. The staff were aware of the risks associated with the use of valproate during pregnancy. Educational material was available to hand out when the medicines were supplied. The pharmacist said he had spoken to patients who were at risk to make them aware of the pregnancy prevention programme.

Some medicines were dispensed in multi-compartment compliance aids. Before a person was started on a compliance aid the pharmacy would refer them to their GP to complete an assessment about their

suitability. Electronic records containing the details of people's current medication were kept for each patient. Any medication changes were confirmed with the GP surgery before the records were updated. Hospital discharge sheets were sought, and a record made in a diary for future reference. Disposable equipment was used to provide the service and initialled with a dispensing check audit trail. But compliance aid packs were not labelled with medication descriptions, and patient information leaflets (PILs) were not routinely supplied. So people may not be able to identify the individual medicines or have all of the information they need to take the medicines safely.

Medicines were obtained from licensed wholesalers, with unlicensed medicines sourced from a specials manufacturer. The pharmacy was not yet meeting the safety features of the falsified medicine directive (FMD), which is now a legal requirement. Equipment was installed but the pharmacy team had yet to commence routine safety checks of medicines. A date checking matrix was on display which was last signed by staff in August. There were no other records made in 2019. The SI said date checking was completed on a monthly basis, but this had not been recorded. Short dated stock was highlighted using a sticker. A spot check of medicines in the dispensary did not find any out of date stock. Liquid medication did not always have the date of opening written on. This included a bottle of morphine sulphate oral solution which expired 3 months after opening. So members of the pharmacy team may not know how long the medicines had been open or whether they remained fit for purpose.

Controlled drugs were stored in the CD cabinet, with some segregation between current stock, patient returns and out of date stock. CD denaturing kits were available for use. There was a clean medicines fridge with a minimum and maximum thermometer. Records of the current temperature were made each day and had been at an appropriate level for the last three months. But the minimum and maximum temperatures were not recorded. So the pharmacy could not demonstrate that the temperatures had remained within the required range. Patient returned medication was disposed of in designated bins located away from the dispensary. A folder containing drug alerts was available but had not been updated since 2018. The pharmacy received drug alerts from MHRA, but they could not demonstrate who and what action they had taken. A spot check of alerts received within the last 4 months did not find any affected stock.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy's team members have access to the equipment they need for the services they provide. And they maintain the equipment so that it is safe to use.

Inspector's evidence

The staff had access to the internet for general information. This included access to the BNF, BNFc and drug tariff resources. All electrical equipment appeared to be in working order. According to the stickers attached, electrical equipment had last been PAT tested in 2015. There was a selection of liquid measures with British Standard and Crown marks. Separate measures were designated and used for methadone. The pharmacy also had counting triangles for counting loose tablets including a designated tablet triangle for cytotoxic medication. Equipment was kept clean by the pharmacy team.

Computers were password protected and screens were positioned so that they weren't visible from the public areas of the pharmacy. A cordless phone was available in the pharmacy which allowed the staff to move to a private area if the phone call warranted privacy. The consultation room was used appropriately; patients were offered its use when requesting advice or when counselling was required. Substance misuse clients were directed to the use of the consultation room to provide 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.