General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: West End Pharmacy, 3 Heysham Road, MORECAMBE, Lancashire, LA3 1DA

Pharmacy reference: 1084040

Type of pharmacy: Community

Date of inspection: 07/10/2019

Pharmacy context

This is a community pharmacy located next to a medical centre. There is also another pharmacy inside the medical centre. It is situated in a residential area of Morecombe in Lancashire. The pharmacy dispenses NHS prescriptions, private prescriptions and sells over-the-counter medicines. It also provides a range of services including seasonal flu vaccinations and emergency hormonal contraception. A number of people receive their medicines in multi-compartment compliance aids.

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	1.6	Standard not met	The pharmacy did not keep accurate records for the responsible pharmacist. This does not meet current legal requirements and the pharmacy may not be able to show who a pharmacist was at a certain point in time.
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 does not have a reliable programme to check the expiry dates of its stock. And there are expired medicines on the dispensary shelves. Stock medicines are not always labelled with all of the information required by law, such as expiry dates and batch numbers. This may increase the risk of error. A number of P-medicines were available for self-selection in the retail area. So sales may not always be appropriately controlled.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

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

Summary findings

The pharmacy team has written procedures to help it work effectively. But the procedures do not contain a date of issue and have not been signed by the pharmacy team. So they may not always be properly followed. The pharmacy does not keep accurate records of the responsible pharmacist, which are needed by law. So, it may not be able to show who the pharmacist was at a certain point in time. Members of the team are given training so that they know how to keep private information safe. But they do not always record things that go wrong, so they may miss some opportunities to learn.

Inspector's evidence

There was a set of standard operating procedures (SOPs). But there was no date of when they were issued or when they are due to be reviewed. So it is not known how well they reflected current practice. Staff said they had read the SOPs but there were no signatures to indicate they had done this.

Dispensing errors were recorded electronically. A recent error involved the incorrect supply of a combination eye drop medicine. The pharmacist had investigated the error and action taken to help reduce the risk of further errors included highlighting the stock location of combination eye drops. There was a paper log to record near miss incidents, but there were few records made. The pharmacy team said some errors may not be recorded. The pharmacist would also highlight mistakes to staff at the point of accuracy check and ask them to rectify their own errors. He gave examples of the action taken to help prevent similar mistakes, which included moving different strengths of sertraline away from each other. But the near miss records were not reviewed to identify patterns or trends. The pharmacist shared learning identified by the NPA using their quarterly error reports. In response to a risk identified in one of the reports the pharmacist had highlighted the dispensary location of finasteride tablets.

Roles and responsibilities of the pharmacy team were described in individual SOPs. The new 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) had their notice displayed prominently. The pharmacy had a complaints procedure. A notice in the retail area advised people they could discuss any concerns or feedback with the pharmacy team. Complaints would be recorded to be followed up. A current certificate of professional indemnity insurance was on display in the pharmacy.

RP records could be made either on the pharmacy computer or as a paper-based record, but there was no consistency as to which was used and often no record appeared to have been made at all. During a three-month period, there were 21 days where no RP record had been made in either format. Controlled drugs (CDs) registers were maintained with running balances recorded. The balance of MST 10mg MR tablets and Longtec 20mg MR tablets were checked and both found to be accurate. Patient returned CDs were recorded in a separate register. Records for private prescriptions, emergency supplies and unlicensed specials appeared to be in order.

An information governance (IG) policy was available. The pharmacy team had read the policy and had signed confidentiality agreements. When questioned, the dispenser was able to describe how confidential information was destroyed using the on-site shredder. A privacy notice was on display in

the retail area explaining how the pharmacy handled and stored people's information.

Safeguarding procedures were included in the SOPs. The pharmacy team had completed a safeguarding e-learning and pharmacy professionals had completed level 2 safeguarding training. Contact details of the local safeguarding board were available. The dispenser said she would initially report any concerns to the pharmacist on duty.

Principle 2 - Staffing ✔ Standards met

Summary findings

There are enough staff to manage the pharmacy's workload and they are appropriately trained for the jobs they do. Members of the pharmacy team complete some additional training to help them keep their knowledge up to date. But this is not structured so learning needs may not always be identified or addressed.

Inspector's evidence

The pharmacy team included two pharmacists, two accuracy checking technicians (ACTs), a dispenser and a medicine counter assistant (MCA). There was also a new member of staff who was working on the medicines counter. She had commenced work about two months ago and was yet to be enrolled onto a training course. All other members of the team had completed the necessary training for their roles. The normal staffing level was a pharmacist, one or two ACTs, and one or two other staff. The volume of work appeared to be managed. Staffing levels were maintained by part-time staff and a staggered holiday system.

Members of the pharmacy team completed some additional training, for example they had recently completed a training pack about Children's oral health. Training records were kept showing that ongoing training was up to date. Staff were allowed learning time to complete training. But further training was not provided in a structured or consistent manner.

The technician gave examples of how she would sell a pharmacy only medicine using the WWHAM questioning technique, refuse sales she felt were inappropriate and refer people to the pharmacist if needed. The pharmacist said he felt able to exercise his professional judgment and this was respected by the superintendent. The dispenser said she received a good level of support and felt able to ask for further help. Staff did not have formal appraisals so learning and development needs may not always be addressed. The dispenser said she felt able to raise any concerns she had. Staff were aware of the whistleblowing policy and said that they would be comfortable reporting any concerns to the SI. There were no service based targets set by the company.

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, microwave, 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, and adequate lighting. The patient entrance to the consultation room was clearly signposted.

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

Summary findings

The pharmacy's services are easy to access. But it does not have reliable systems in place to check its medicine stock. There are some medicines on the dispensary shelves that have passed their expiry date. And some medicines are not labelled with all of the information that is needed by law. This means there is more chance of errors being made. And over-the-counter medicines are stored where people can self-select them. So they may not always get the most suitable treatment.

Inspector's evidence

Access to the pharmacy was suitable for wheelchair users. The pharmacy team said they would assist a patient where they could, but there was limited wheelchair access to the consultation room. So some people may not be able to access all of the pharmacy's services. 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 using a signposting folder. The pharmacy opening hours were displayed at the entrance of the pharmacy.

A repeat prescription service was offered where patients would contact the pharmacy to order their medication. A record of requested medication was kept, and any missing items were queried with the GP surgery. The pharmacy had a delivery service. Deliveries were segregated after their accuracy check and a delivery signature was used to obtain signatures from the recipient to confirm delivery. Some deliveries were posted through the letterbox or left in a designated location following a verbal risk assessment. This was completed on an individual delivery basis. Unsuccessful deliveries would be returned to the pharmacy and a card posted through the letterbox indicating the pharmacy had attempted a delivery. A separate signature was obtained when CDs were delivered to confirm their receipt.

The pharmacy team initialled dispensed by and checked by boxes on dispensing labels to provide an audit trail. They used dispensing baskets to separate individual patients' prescriptions to avoid items being mixed up and the baskets were colour coded to help prioritise dispensing. Owing slips were in use to provide an audit trail if the full quantity could not be immediately supplied. The ACT was permitted to perform the final accuracy check on medicines which were repeated items. New medicines, or changes in prescriptions would be flagged to the pharmacist. But there was no audit trail to indicate who was responsible for the clinical check. So there is a risk some medicines may be supplied without suitable checks.

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 routinely highlighted. So the pharmacy team may not know when they are being handed out and there is a risk that the medicines 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 would speak to patients to check the supply was suitable but said there were currently no patients that met the risk criteria.

Some medicines were dispensed in multi-compartment compliance aids. The pharmacy would refer people to their GP in order to assess their suitability to receive their medicines in a compliance aid. A record sheet was kept for each patient, containing details of their current medication. Any medication changes were confirmed with the GP surgery before the record sheet was amended. Disposable trays were used but they were not always labelled with medication descriptions. So people may not always be able to identify the individual medicines. Patient information leaflets (PILs) were routinely supplied.

The pharmacy provided a seasonal flu vaccination service using a patient group direction (PGD). The PGD was available and had been signed by the pharmacist providing the service. The pharmacist had completed the necessary training and suitable equipment was available to provide the service.

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 record was available. The last record made was for February 2019. There was no set structure for when expiry dates were checked. Short dated stock was highlighted using a sticker. A spot check of the dispensary found a number of medicines which had expired. Liquid medication did not always have the date of opening written on. So members of the pharmacy team may not know how long the medicines had been open or whether they remained fit for purpose. A number of medicines were stored loosely on the dispensary shelves. For example, loose foil strips of tablets outside of medicine boxes. A number of bottled medicines did not contain all of the necessary information, such as expiry dates and batch numbers.

A number of P-medicines were stored on open shelves in the retail area. There was nothing to prevent self-selection, so sales may not always be appropriately controlled. Controlled drugs were stored appropriately in the CD cabinets, with clear segregation between current stock, patient returns and out of date stock. CD denaturing kits were available for use. There were clean medicines fridges, each with a thermometer. The minimum and maximum temperatures were being recorded daily and records showed they had been in range for the last 3 months. Patient returned medication was disposed of in designated bins located away from the dispensary. Drug alerts were received by email from the MHRA. But there was no record of what action had been taken. So the pharmacy was not able to demonstrate that alerts have been dealt with appropriately.

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 been PAT tested in June 2016. 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. 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.