General Pharmaceutical Council

# Registered pharmacy inspection report

**Pharmacy Name:** Seascale Pharmacy, Gosforth Road, SEASCALE, Cumbria, CA20 1PR

**Pharmacy reference:** 1084737

**Type of pharmacy:** Community

**Date of inspection:** 25/09/2019

## Pharmacy context

This is a community pharmacy in the village of Seascale, Cumbria. The premises also contains a convenience store and a post office. 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. And it offers services including medicines use reviews (MURs) and the NHS New Medicines Service (NMS). It also supplies medicines in multi-compartmental compliance packs to people living in their own homes.

## Overall inspection outcome

✔ **Standards met**

**Required Action:** None

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 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

The pharmacy adequately identifies and manages the risks associated with its services. And it keeps people's private information secure. The pharmacy team members have the knowledge to help protect the welfare of vulnerable adults and children. They listen to the feedback they receive from people who use the pharmacy, to help improve services. The pharmacy team members discuss and learn from errors they make while dispensing. And they take some steps to make sure they don't make a similar error again. The pharmacy team members mostly keep the records they must by law. And they have written procedures to follow. But these aren't up to date. So, the team members may not know the safest and most effective way to work.

### Inspector's evidence

The pharmacy was relatively small but had ample bench space in the dispensary. It had a small open plan retail area which led to the pharmacy counter. The pharmacy counter provided a barrier between the retail area and the dispensary. The pharmacist used the bench in the dispensary closest to the pharmacy counter to do final checks on prescription. This helped oversee sales of over-the-counter medicines and conversations between team members and people at the counter.

The pharmacy had a set of standard operating procedures (SOPs). And these were held in a ring binder. There was an index. And so, it was easy to find a specific SOP. The SOPs covered various processes including taking in prescriptions and dispensing. The team members were seen working in accordance with the SOPs. The SOPs were prepared by a third-party contractor in 2011. The SOPs were due to be reviewed every two years. But the last recorded review was in 2013. So, the procedures the team followed may be out of date. Each team member had read the SOPs that were relevant to their role in the pharmacy. A team member said she would ask the pharmacist if there was a task they were unsure about. Or felt unable to deal with.

The pharmacist highlighted near miss errors that were spotted during dispensing. And the pharmacist discussed the error with the team member. Occasionally, the team members recorded the details of any errors they made into a near miss log. But they didn’t use the log regularly. And very few mistakes were recorded in 2019. The team members talked about the errors and why they happened. They identified rushing or misreading the prescription were the most common errors. The pharmacist encouraged the team members to take more time when dispensing prescriptions, even when the pharmacy was busy. The pharmacy did not have a system to formally analyse the near miss errors for any trends or patterns. But despite the lack of records, the team had made some changes to their practice to prevent similar mistakes happening again. This included the separation of ramipril tablets and capsules. The pharmacy had a process to record dispensing errors that had been given out to people, which included keeping a copy of the report in the pharmacy for future reference. The report template included the details of who was involved, what happened, why it happened, and what actions the pharmacy intended to do to prevent a similar error happening again. The team members described some examples, but they were unable to locate any completed reports.

The pharmacy advertised how the people who used the pharmacy could make comments, suggestions and complaints, via a notice in the retail area. The pharmacist was in the process of completing an

annual patient satisfaction survey. People were asked to complete a short questionnaire about the service they had received from the pharmacy. And suggest ways the pharmacy could improve. The pharmacy had recently started selling electronic cigarettes following several requests from people who used the pharmacy.

The pharmacy had up-to-date professional indemnity insurance. The responsible pharmacist notice displayed the name and registration number of the responsible pharmacist on duty. Entries in the responsible pharmacist record mostly complied with legal requirements. But the pharmacists didn't always record the time their responsible pharmacist duties ended. This is not in line with requirements. The pharmacy kept complete records of private prescription and emergency supplies. The pharmacy kept controlled drugs (CDs) registers. But they were not always completed fully, as some headers were missing. The pharmacy team checked the running balances against physical stock when new stock was delivered, or stock was supplied to people. But didn't complete a regular full stock check. The advantages of this were discussed with the team. The pharmacy kept complete records of CDs returned by people to the pharmacy.

The team held records containing personal identifiable information in areas of the pharmacy that only team members could access. Confidential waste was placed into a separate bin to avoid a mix up with general waste. The confidential waste was periodically destroyed using a shredder. The pharmacy did not outline to people using the pharmacy how it stored and protected their information. The team members understood the importance of keeping people’s information secure. Each team member had completed various training modules on information governance and records were seen. The modules included signing a confidentiality agreement, reading the pharmacy information governance policy and obtaining patient consent.

The pharmacist on duty had completed training on the safeguarding of vulnerable adults and children up to level 2 via the Centre for Pharmacy Postgraduate Education. Another team member had completed some training as part of her previous employment. Two team members had recently completed ‘dementia friends’ training. The team members gave several examples of symptoms that would raise their concerns in both children and vulnerable adults. A counter assistant said she would discuss their concerns with the pharmacist on duty, at the earliest opportunity. The pharmacy did not provide any written guidance on how to manage or report a concern or have access to the contact details of the local safeguarding team. And so, the team members may struggle to effectively manage or report a concern.

## Principle 2 - Staffing ✔ Standards met

### Summary findings

The pharmacy has enough skilled team members to provide its services. And they complete ad-hoc learning to keep their knowledge up to date. They talk together informally about how to make improvements to the pharmacy's services. And they feel comfortable to raise professional concerns if necessary. But they don't have regular meetings to discuss their performance or training needs. So, they may miss out on opportunities to learn and improve.

### Inspector's evidence

At the time of the inspection, the team members present were the regular pharmacist who worked 4 days a week and three other team members. One of the team members worked in the dispensary and was involved in the dispensing of medicines. But the team member had not completed any formal dispensing qualifications. The two other team members worked on the pharmacy counter and their main roles involved taking in prescriptions and handing out dispensed medicines and selling over-the-counter products. But one of the team members had not completed a counter assistant course. The pharmacist on duty supervised the team members. And they were seen asking appropriate questions and involving the pharmacist in offering advice to people who were purchasing over-the-counter products for various minor ailments. The team members who were not present during the inspection included two team members who dispensed medicines and three other team members who worked on the counter. Directly, following the inspection, the pharmacy owner provided the inspector with a list of the qualifications of each team member and evidence he had enrolled each unqualified team member onto an appropriate course. This gave assurances that the team members were in training or suitably qualified, to carry out roles such as dispensing and selling over-the-counter medicines.

The pharmacy did not provide its team members with a structured training plan. But the team members were able to take some time during the working day to read training material that the pharmacy had received from various healthcare companies. The team members also often attended local training events. A recent event had raised their awareness about dementia and how they could be confident to spot the signs. The pharmacy had an appraisal process, but the team members had not had an appraisal for approximately two years. The team members could informally discuss their personal development. But no examples were provided.

The team did not have regular, formal meetings. But as it was a small team, the team members discussed topics such as company news, targets and patient safety, when the pharmacy was quiet. If a team member was not present during the discussions, they were updated the next time they attended for work. The team members openly and honestly discussed any mistakes they had made while dispensing and discussed how they could prevent the mistakes from happening again. And the team members felt comfortable to give feedback to the pharmacy’s owners, to help improve the pharmacy’s services. The team members were able to discuss any professional concerns with the pharmacist or the superintendent pharmacist. They said they felt comfortable to raise any concerns and were confident the concerns would be listened to and any changes made if necessary. The team was not set any specific targets to achieve

## Principle 3 - Premises ✔ Standards met

### Summary findings

The pharmacy is secure and suitably maintained. It has a sound-proofed room, which is adequate for people to have private conversations with the pharmacy's team members.

### Inspector's evidence

The pharmacy was clean, professional in appearance and well maintained. It had a limited amount of bench space available for the volume of dispensing being completed. And some of the benches were cluttered and several baskets containing medicines and prescriptions were kept on the dispensary floor. The risk of trip hazards and medicines being mixed up due to the clutter, was discussed with the team.

There was a clean, well-maintained sink in the dispensary for medicines preparation. There was a WC and sink available for staff use. And it was well maintained. The pharmacy had a sound-proofed consultation room which contained adequate seating facilities. The room was used for private consultations for services such as medicines use reviews. It was also used as a staff kitchen area. The room was kept clean and the table used during consultations was kept free of any staff related items. The room was signposted by a sign on the door. The temperature was comfortable throughout the inspection. Lighting was bright throughout the premises.

## Principle 4 - Services ✔ Standards met

### Summary findings

The pharmacy provides an appropriate range of services to help people meet their health needs. And the pharmacy helps make these services accessible to people. The pharmacy has controls in place to help deliver some of its services effectively. It manages the risks associated with supplying medicines in multi-compartmental packs with suitable processes. But it doesn't manage other services as well. The team members don't obtain signatures on receipt when they deliver medicines to people at home. And they don't always supply people with written slips to let people know when the pharmacy can't supply all their medicines. This means the pharmacy has incomplete audit trails in case of mistakes and queries. The pharmacy sources, stores and manages its medicines safely.

### Inspector's evidence

The pharmacy had level access from the street to a push/pull entrance door. This allowed easy access for people who had prams, pushchairs or used wheelchairs. The pharmacy advertised its services and opening hours in the retail area. Seating was provided for people waiting for prescriptions. Large print labels were provided on request to help people with a visual impairment. The team members had access to the internet. Which they used to signpost people requiring a service that the team did not offer.

The team members regularly used various stickers during dispensing and they used these as an alert before they handed out medicines to people. For example, to highlight interactions between medicines or the presence of a fridge line or a controlled drug that needed handing out at the same time. There were occasions when the pharmacist worked alone and so completed both the dispensing and checking process of dispensing. The pharmacist said she always tried to take a mental break between the dispensing and checking processes and signed the dispensing label when each process was complete. And so, a robust audit trail of the process was in place. They used baskets to hold prescriptions and medicines. This helped the team members stop people’s prescriptions from getting mixed up. The team used marker pens to highlight the date of issue of CDs that did not require safe custody. This system helped the team members check the dates and helped prevent them from handing out any CDs to people after the prescription had expired. The pharmacy did not always provide owing slips to people on occasions when the pharmacy could not supply the full quantity prescribed. And so, people were not given a record of the medicines they were outstanding. The potential issues of this, such as inaccurate dispensing records, was discussed with the team. And they said they would begin using owing slips as soon as possible.

The pharmacy offered a service to deliver medicines to people’s homes in exceptional circumstances. The deliveries were done by one of the team members. And the pharmacy made around one delivery every five to six weeks. But it did not ask people to sign that they had successfully received their medicines. And so, an audit trail that could be used to solve any queries, was not available. The pharmacy scanned barcodes on address labels when dispensed medicines were handed out to people. This allowed them to keep an audit trail of who and when medicines were collected. And the audit trail was used to resolve any queries.

The team members were aware of the risks associated with the supply of high-risk medicines. And they used written notes for warfarin, lithium and methotrexate to attach to bags which contained these

medicines. The alert stickers were used to remind the team members to show the bag to the pharmacist before it was handed to the person. The pharmacist often gave the person additional advice if there was a need to do so. 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. The team members were aware about the requirements of the valproate pregnancy prevention programme. But they did not have access to any written information to provide people to take away with them to help them manage the risks. The team discussed how they could obtain a supply. The team had not completed a check to see if any of its regular patients were prescribed valproate and met the requirements of the programme.

The pharmacy supplied medicines in multi-compartmental compliance packs for people living in their own homes. And the pharmacy supplied the packs to people on either a weekly or monthly basis. The team members were responsible for ordering the person's prescription. And they did this around a week in advance. And then they cross-referenced the prescription with a master sheet to ensure it was accurate. The team members queried any discrepancies with the person's prescriber. The team members recorded details of any changes, such as dosage increases and decreases, on the master sheets. They dispensed the packs on a side bench which was out of the line of sight of the retail area. This was to make sure they weren't distracted while dispensing. The packs had dispensing labels attached. And the labels contained information to help people visually identify the medicines. The team routinely provided patient information leaflets with the packs.

Pharmacy only (P) medicines were stored behind the pharmacy counter. The storage arrangement prevented people from self-selecting these medicines. The pharmacy had a date checking schedule to be completed every six months and it highlighted short-dated stock. But it did not keep a record of the process. And so, an audit trail was not in place. No out of date medicines were found following a random check. The team members recorded the date liquid medicines were opened on the pack. So, they could check they were in date and safe to supply. The team members were not scanning products and undertaking manual checks of tamper evident seals on packs, as required under the Falsified Medicines Directive (FMD). The pharmacy did not have the equipment available to help them comply with FMD. And the team members had not completed any training. They were unsure of when the pharmacy was expected to comply with the requirements of FMD.

The pharmacy had medicinal waste bins and CD denaturing kits to help the pharmacy team manage pharmaceutical waste. Fridge temperatures were recorded daily using digital thermometers. But the team members were recording the current fridge temperature instead of the minimum and maximum temperatures as required. This was discussed with the team. The minimum and maximum temperature ranges were checked during the inspection. And these were within the correct ranges. The pharmacy obtained medicines from several reputable sources. Drug alerts were received via email to the pharmacy and actioned. The pharmacy kept a record of what action had been taken. And so, a robust audit trail was in place that could be used in the event of a query.

## Principle 5 - Equipment and facilities ✔ Standards met

### Summary findings

The pharmacy's equipment is clean and safe to use. And the pharmacy uses its equipment and facilities to protect people's confidentiality.

### Inspector's evidence

References sources were in place. And the team had access to the internet as an additional resource. The resources included hard copies of the British National Formulary (BNF) and the BNF for Children. The pharmacy used a range of CE quality marked measuring cylinders. Separate cylinders were used to dispense methadone. The fridge used to store medicines was of an appropriate size. And the medicines inside were organised in an orderly manner. There was no evidence of electrical equipment having been subjected to portable appliance testing. But the equipment appeared to be in good working order and well maintained. 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 positioned to ensure confidential information wasn't on view to the public. The computers were password protected. Cordless phones assisted the team 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. |