General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Holmwood Pharmacy, The Health Centre, Franklin Avenue, TADLEY, Hampshire, RG26 4ER

Pharmacy reference: 1085498

Type of pharmacy: Community

Date of inspection: 24/04/2019

Pharmacy context

This is a community pharmacy located within a GP surgery in Tadley in Hampshire. A range of people use the pharmacy's services. The pharmacy dispenses NHS and private prescriptions. It also offers a few services such as Medicines Use Reviews (MURs) and the New Medicine Service (NMS). The pharmacy supplies medicines to care homes and some people receive multi-compartment compliance aids if they find it difficult to take their medicines on time. These aids are assembled from another part of the company's premises and people either collect these onsite or they are delivered to their homes.

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

The pharmacy identifies and manages some risks effectively. The pharmacy team members record mistakes that occur during the dispensing process, they learn from these and act to prevent future mistakes occurring. But, they don't formally review them or record all the details. This could mean that opportunities to spot patterns or trends are missed. Members of the pharmacy team understand how they can protect the welfare of vulnerable people. And, they protect people's private information well. In general, the pharmacy keeps its records in accordance with the law.

Inspector's evidence

The pharmacy held a range of documented standard operating procedures (SOPs) to support its services. These were prepared in 2019. Roles and responsibilities of staff were defined. Staff had signed to state that they had read SOPs. At the point of inspection, there was no SOP to provide the team with guidance about the off-site dispensing process. Following the inspection, the pharmacy manager confirmed via email that this SOP had subsequently been implemented.

Most of the pharmacy's workload came from the adjacent GP surgery. This was manageable.

There was information on display about the pharmacy's complaints procedure. This included the pharmacy's practice leaflet. The pharmacy informed people that an external contractor (NWOS) was being used to dispense some appliances. This was through a notice that was on display. It also informed people that multi-compartment compliance aids devices were being dispensed off-site. Staff stated that people were verbally informed about this process.

Near misses were recorded routinely by the team. These were reviewed collectively by the pre-registration pharmacist every month and the team's awareness about trends or patterns were raised through team huddles. Staff described separating medicines with similar packaging or for example, any that had been involved in errors previously. This included moving olmesartan away from omeprazole and cyanocobalamin away from cyclizine. The team had also identified and highlighted look-alike and sound-alike (LASA) medicines on shelves. Caution stickers were placed in front of relevant stock as an additional visual alert. However, there were no details seen documented for the past few months to demonstrate the review process.

Incidents were handled by pharmacists. A documented complaints process was present. The pharmacist's procedure was in line with this and included checking relevant details, documenting details and faxing this to the pharmacy's head office and informing the person's GP if any incorrect medicine was taken.

Team members could identify signs of concern to safeguard vulnerable people. In the event of a concern, the responsible pharmacist (RP) would be informed. Both pharmacists were trained to level 2 via the Centre for Pharmacy Postgraduate Education (CPPE), staff were trained through reading relevant information and were trained as dementia friends. Relevant local contact details and policy information was available.

The pharmacy displayed information so that people could know how their privacy was maintained. There was no confidential material left within public facing areas. Confidential waste was

shredded. Bagged prescriptions awaiting collection were stored in a location where sensitive information was not visible from the retail space. Staff had signed confidentiality agreements and were trained on the EU General Data Protection Regulation (GDPR). There were also a set of information governance SOPs as guidance for the team. Summary Care Records were accessed for emergency supplies and consent was obtained verbally from people to access their records.

The correct RP notice was on display. This provided details of the pharmacist in charge of operational activities.

Most of the pharmacy's records relating to its services were compliant with statutory requirements. This included records of unlicensed medicines, emergency supplies, private prescriptions, most entries within the RP record and a sample of registers checked for controlled drugs (CDs). Balances for CDs were checked and documented every two weeks. On randomly selecting CDs held in the cabinet, their quantities matched balances recorded in corresponding registers.

There were odd missing entries within the RP record where pharmacists had failed to record the time that their responsibility ceased.

The pharmacy's professional indemnity insurance arrangements was via the National Pharmacy Association (NPA) and due for renewal after 30 June 2019.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough staff to manage its workload safely. It now ensures that all its team members are undertaking appropriate training for their roles. In general, members of the pharmacy team understand their roles and responsibilities. But, once they have completed basic training, they are not provided with many resources or training materials to help keep their knowledge and skills up to date. This could affect how well they care for people in the future and the advice they give. And, the pharmacy's team members do not have regular performance reviews. This could mean that gaps in their skills and knowledge are not identified.

Inspector's evidence

The pharmacy dispensed 20,000 to 21,000 prescription items every month, it supplied around 100 people with multi-compartmnent compliance aids that were dispensed off-site, at the company's warehouse in Langley and supplied medicines to around seven care homes with a total capacity for 33 residents.

The pharmacy's staffing profile included two pharmacists, one of whom was the pharmacy manager, a pre-registration pharmacist, three trained dispensing assistants, one trainee dispensing assistant who was undertaking accredited training with Counter Intelligence, four delivery drivers and two medicine counter assistants (MCAs).

The latter were employed since December 2018 and at the point of inspection were not enrolled onto any accredited training that would support their role. This was not in line with the GPhC's minimum training requirements which specifies that any assistant given delegated authority to carry out certain activities should have undertaken, or be undertaking, an accredited course relevant to their duties within three months of commencing their role. On discussing this with the pharmacy manager, she immediately provided confirmation by email that both members of staff were subsequently enrolled onto appropriate training courses following the inspection.

The team's certificates of qualifications obtained were seen.

Counter staff knew which activities were permissible in the absence of the RP. They used relevant questions to obtain information when people requested over-the-counter (OTC) medicines and ran all transactions past pharmacists. Sufficient knowledge of OTC medicines was held.

The pre-registration pharmacist was provided with protected time to complete her studies. Some staff described using emails, updates from the company, leaflets and taking instruction from pharmacists to keep their knowledge up to date. Other team members explained that they could use counter skills booklets and their previous course material to refer to, to assist them with keeping their knowledge current. The inspector was told that the team had not received any appraisals.

The pharmacist described an expectation to achieve 400 MURs annually. This was described as manageable with no pressure applied to achieve.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are clean, secure and provide a professional environment for the delivery of its services.

Inspector's evidence

The premises consisted of a spacious retail area, the main dispensary was at the rear, there was a small stock room to one side and a further segregated dispensary that was used to prepare medicines for the care homes.

The retail space also included another stock room and two consultation rooms. There was key coded entry for the latter that prevented free access into these areas.

The pharmacy was suitably lit, well-ventilated and the retail space was professional in appearance. All areas were clean.

Pharmacy only (P) medicines were stored behind the front counter. Staff were always within the vicinity. This helped restrict the self-selection of P medicines.

Two signposted consultation rooms were available to provide services and private conversations. They were of a suitable size for this activity.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy obtains its medicines from reputable sources. But, some medicines are stored in poorly labelled containers. This makes it harder for the team to check the expiry date, assess the stability or take any necessary action if the medicine is recalled. The pharmacy team makes checks to ensure the fridges used to store medicines are working properly. But, team members don't record details of the action taken when the temperature is outside the maximum range. So, they may not always be able to demonstrate that medicines have been appropriately stored. In general, team members ensure pharmacy services are provided safely and effectively. But, the pharmacy does not always provide medicine leaflets. This means that people may not have all the information they need to take their medicines safely. And, they are not removing date-expired prescriptions in time. This increases the chance of these medicines being supplied unlawfully.

Inspector's evidence

There were two entry points into the pharmacy. The main entrance was from inside the doctor's surgery and the other from a wide, side door, that opened onto one side of the building. This meant that people that required wheelchair access could easily use the pharmacy's services from these level entrances. The retail space was also made up of clear open space and wide aisles which further assisted this. There were four seats available for people waiting for prescriptions and some car parking spaces at the rear of the premises. The team described facing people who were partially deaf to help them to lip read and used representatives for people who were visually impaired.

There were some leaflets available for people to access information about other local services. There was also a health promotion zone in one section of the retail space. Staff explained that they showed people the information and provided advice where possible. They had made some referrals in the past to the smoking cessation clinic.

People were signposted to other organisations from the team's own local knowledge of the area and they could use online resources to assist them with this.

The pharmacy team used baskets to hold each prescription and associated medicines. This prevented any inadvertent transfer. Staff used a dispensing audit trail to verify their involvement in processes. This was through a facility on generated labels.

People prescribed higher risk medicines were identified and counselled when required. People prescribed warfarin in the area had been changed to other medicines such as apixaban. Staff were aware of risks associated with valproate. They explained that pharmacists were made aware if prescriptions for people who may become pregnant were seen.

For multi-compartment compliance aids devices: prescriptions were processed through the pharmacy system and relevant paperwork for each individual person filled in. This was then taken by the driver to the company's warehouse for assembly. There were records in place to demonstrate which person's record had been taken up as well as when assembled devices were received back into the pharmacy. Staff checked that devices received matched details on these records upon receipt of the devices.

Medicines were provided to the care homes as original packs or within compliance devices. The homes ordered prescriptions for their residents. Staff liaised with them regarding changes, missing or new items. Patient information leaflets (PILs) were not routinely supplied for some of the homes. Staff explained that they had not had to pass any drug alerts to the homes. There were no residents with higher risk medicines. Staff had not been approached to provide advice regarding covert administration of medicines to care home residents.

There were audit trails in place to verify when and where medicines were delivered. CDs and fridge items were identified and people's signatures were routinely obtained, once they were in receipt of their medicines. Failed deliveries were brought back to the pharmacy with notes left to inform people of the attempt that had been made. Medicines were not left unattended.

Medicines and medical devices were obtained from licensed wholesalers such as AAH, Alliance Healthcare, Trident and Waymade.
Unlicensed medicines were obtained through Alliance Healthcare.

Staff were unaware when asked about the process involved for the European Falsified Medicines Directive (FMD). Relevant equipment was in place but not set up, to enable use at the point of inspection. The pharmacy manager explained that all staff had read the SOP for this process.

Medicines were stored in an organised manner in the dispensary and staff described date-checking these for expiry as often as they could. Short dated medicines were identified and highlighted. A schedule was in place to demonstrate when medicines were last checked for expiry. There were no date expired medicines or mixed batches seen. Liquid medicines were marked with the date they were opened.

Several medicines that were stored outside of their original containers were not marked with full and relevant details (such as expiry dates and batch numbers).

In general, CDs were stored under safe custody. The key to the cabinet was maintained in a manner that prevented unauthorised access during the day.

Details of the minimum and maximum temperatures for the fridges were maintained on a daily basis. However, some records documented these as consistently being outside the range (either greater than eight or eleven degrees Celsius). There was no information recorded to demonstrate whether any remedial action was taken in response to this.

Prescriptions, once assembled were held within an alphabetical retrieval system. Fridge items and CDs (schedules 2 and 3) were identified and details were marked on prescriptions to highlight these. Not all schedule 4 CDs were highlighted to assist with identifying their 28-day prescription expiry although staff could identify these. Uncollected medicines were checked every few months according to staff.

Date expired prescriptions were present (dated 3 September 2018)

Once accepted, the team stored returned medicines that required disposal within appropriate receptacles. People bringing back sharps for disposal were accepted provided these were in sealed bins. Returned CDs were brought to the attention of the RP with relevant details entered into a CD returns register. The audit trail of receipt and destruction was complete.

Drug alerts were received by email. The process involved checking for stock and acting as necessary. An audit trail was available to verify the process.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs to provide its services safely.

Inspector's evidence

The pharmacy was equipped with current versions of reference sources.

Clean, crown stamped conical measures were present for liquid medicines. Counting triangles were also available. This included a separate one for cytotoxic medicines.

The dispensary sink used to reconstitute medicines was clean. There was hot and cold running water available as well as hand wash present.

Medical fridges were available to store medicines. See principle 4 regarding the temperature of these. The CD cabinets were secured in line with legal requirements.

The blood pressure machine was described as checked for suitability a few months before the inspection.

Computer terminals were positioned in a way that prevented unauthorised access. A shredder disposed of confidential waste. The team used their own smart cards to access electronic prescriptions. These were stored securely overnight.

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.