General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: David Stearne Pharmacy, Moss Side Village Centre, Dunkirk Lane, Moss Side, LEYLAND, Lancashire, PR26 7SN

Pharmacy reference: 1085891

Type of pharmacy: Community

Date of inspection: 07/07/2022

Pharmacy context

This is a community pharmacy located on a local shopping parade. It is situated in the village of Moss Side, near Leyland in Lancashire. The pharmacy dispenses NHS prescriptions, private prescriptions and sells over-the-counter medicines. The pharmacy supplies medicines in multi-compartment compliance aids for some people to help them take the medicines at the right time.

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 keeps the records it needs to by law. And members of the team know how to keep private information safe. The pharmacy has written procedures which helps to ensure the safety and effectiveness of pharmacy services. And members of the pharmacy team discuss things that go wrong, but they do not record them. So they may miss some learning opportunities.

Inspector's evidence

There was a set of standard operating procedures (SOPs), some of which had intended review dates of April 2020, but the reviews had not yet been completed. Which meant there was a risk that they may not always reflect current practice. Members of the pharmacy team had signed to say they had read and accepted the SOPs.

A paper log was available to record near miss incidents, but none had been recorded for some time. The pharmacist said he would highlight any mistakes to the team. But he did not keep a record of any learning they identified. So they may not always take appropriate action to avoid repetition.

Roles and responsibilities of the pharmacy team were described in individual SOPs. A trainee counter assistant was able to explain 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 which was explained in the practice leaflet. Any complaints were recorded and followed up by the pharmacist manager. A current certificate of professional indemnity insurance was on display.

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

The pharmacy had information governance (IG) procedures and members of the team had completed GDPR training. When questioned, a dispenser was able to describe how confidential information was segregated to be removed by a waste contractor. A privacy notice was on display and explained how data was handled. Safeguarding procedures were included in the SOPs. The pharmacist had completed level 2 safeguarding training. Members of the team knew where to locate the contact details for the local safeguarding board. A dispenser explained that 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 some additional training to help them keep their knowledge up to date. But this is not structured, so learning and development needs may not always be identified or addressed.

Inspector's evidence

The pharmacy team included a pharmacist manager, three dispensers, a trainee medicine counter assistant (MCA) and two delivery drivers. All members of the pharmacy team were appropriately trained or on accredited training programmes. The normal staffing level was a pharmacist and three other support 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 training booklets received through the post. But further training was not provided in a structured or consistent manner.

The counter assistant gave examples of how she would sell a pharmacy only medicine using the WWHAM questioning technique, refuse sales of medicines she felt were inappropriate, and refer people to the pharmacist if needed. Members of the pharmacy team were seen to work well with each other and assist each other with any queries. The dispenser said she felt able to ask for further help from the pharmacist if she needed it. But there was no structured appraisal programme, so development needs may not always be identified. Staff were aware of the whistleblowing policy and said that they would be comfortable reporting any concerns to the manager or SI. There were no specific performance targets set.

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. Customers were not able to view any patient sensitive information due to the position of the dispensary. The temperature was controlled using heaters and fans. Lighting was sufficient. The staff had access to a kitchenette and WC facilities.

A consultation room was available and was clean in appearance. The patient entrance to the consultation room was clearly signposted and indicated if the room was engaged or available.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's services are easy to access. And it manages and provides them safely. It gets its medicines from recognised sources, stores them appropriately and carries out regular checks to help make sure that they are in good condition. But members of the pharmacy team do not always know when they are handing out higher-risk medicines. So they might not check that the medicines are still suitable, or give people advice about taking them.

Inspector's evidence

Access to the pharmacy was level via a single door and was suitable for wheelchair users. Pharmacy practice leaflets gave information about the services offered. The pharmacy opening hours were displayed and a range of leaflets provided information about various healthcare topics. The pharmacy had a delivery service. A record was maintained to provide an audit trail for delivered medicines. Unsuccessful deliveries would be returned to the pharmacy and a card posted through the letterbox indicating the pharmacy had attempted a delivery.

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. Dispensed medicines awaiting collection were kept on a 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 highlighted so that staff could check prescription validity at the time of supply. The pharmacist said he would counsel people who were prescribed high-risk medicines (such as warfarin, lithium and methotrexate) if they had not had them before. But there was no process to highlight high-risk medicines that were waiting to be collected. So members of the team may not always be aware so that they could counsel people and check whether the supply remained appropriate. 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 any at risk patients to check the supply was suitable.

Some medicines were dispensed in multi-compartment compliance aids. Before a person was started on a compliance aid the pharmacist would complete an assessment about their suitability. A record sheet was kept for each patient, containing details about their current medication. Any medication changes were confirmed with the GP surgery before the record sheet was amended. Hospital discharge sheets were sought, and previous records were retained for future reference. Disposable equipment was used to provide the service, and the compliance aids were labelled with medication descriptions and a dispensing check audit trail. Patient information leaflets (PILs) were routinely supplied.

Medicines were obtained from licensed wholesalers, and any unlicensed medicines were sourced from a specials manufacturer. Stock was date checked on a 3-month rotating cycle. A record of completed date checking was kept, and short dated stock was highlighted using a sticker. Liquid medication had the date of opening written on. Controlled drugs were stored appropriately in the CD cabinet, 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 remained in the required range for the last 3 months. Patient returned medication was disposed of in designated bins. Drug alerts were received by email from the MHRA. But there was no record kept about any action taken by the pharmacy. So the pharmacy could not show they had been appropriately actioned.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

Members of the pharmacy team 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. 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.

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.

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.