General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: H A McParland Ltd, T/A Wash Common Pharmacy, Monks Lane, NEWBURY, Berkshire, RG14 7RW

Pharmacy reference: 1087285

Type of pharmacy: Community

Date of inspection: 22/01/2020

Pharmacy context

A pharmacy located next to a surgery in Newbury. The pharmacy dispenses NHS and private prescriptions, sells a range of over-the-counter medicines and provides health advice. The pharmacy also dispenses some medicines in multi-compartment compliance aids (MDS trays or blister packs) for those who may have difficulty managing their medicines at home and they process a high volume of batch prescriptions. The pharmacy provides a supervised consumption service and a local delivery service.

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

Overall, the pharmacy's working practices are safe and effective. It records and reviews its mistakes to learn from them and to prevent them from happening again. Team members keeps people's information safe and they help to protect vulnerable people. The pharmacy also keeps the records required by law. But it is not keeping some of those records up to date, which may mean that discrepancies and mistakes cannot be rectified in a timely manner.

Inspector's evidence

A near miss log was displayed in the dispensary and was seen to be used by the team. The pharmacist explained that she reviewed the near misses verbally with each team member, highlighting their own errors. The team faxed the near misses to the Professional Services Manager for the company who collated the near misses across all branches and send this information back to the pharmacy. The pharmacist explained that this information was shared so the team was aware of all the errors which occurred across the company and could work to prevent similar errors from occurring in their pharmacy.

The pharmacist explained that if the team made a dispensing error, an incident report form was submitted to the Superintendent and then passed on to the Professional Standards Manager. The incident was discussed with the team depending on its nature. The pharmacist explained that an error occurred where paracetamol tablets and capsules were mixed up and so the two forms were separated in the dispensary, and the staff were all made aware of it. The team had also highlighted all the nationally agreed 'Look Alike, Sound Alike' (LASA) drugs on the shelves of the dispensary. There was a workflow in the pharmacy where labelling, dispensing and checking were all carried out at different areas of the work benches. The team ordered stock and labelled repeat prescriptions at the back of the pharmacy to reduce distractions.

SOPs were in place for the dispensing tasks. The team members had all signed the SOPs to say they had read and understood them. Staff roles and responsibilities were described in the SOPs and they were reviewed regularly. There was a complaints procedure in place within the SOPs and the staff were clear on the processes they should follow if they received a complaint. The team carried out an annual CPPQ survey and the results of the latest one were seen to be very positive and displayed on the nhs.uk website. A certificate of public liability and indemnity insurance from the NPA was on display in the dispensary and was valid until the end of June 2020.

A sample of MST 5mg tablets was checked for record accuracy but was seen to be incorrect. There were 34 tablets in the CD cabinet, but the register said there were 154 tablets. It was found that two prescriptions for 60 tablets had been handed out but had not been entered within 24 hours. The pharmacist explained that the team would review their CD entry procedures to ensure that all entries are made in a timely manner. The controlled drug running balance was checked every six weeks. The responsible pharmacist record was held electronically, and the correct responsible pharmacist notice was displayed in pharmacy where the public could see it. The maximum and minimum fridge temperatures were recorded electronically daily and were in the 2 to 8 degrees Celsius range. The electronic private prescription records were completed appropriately. The specials records were complete with the required information documented accurately.

The computers were all password protected and the screens were not visible to the public. Confidential information was stored away from the public and conversations inside the consultation room could not be overheard clearly. There were cordless telephones available for use and confidential waste paper was collected in baskets on the workbenches and later shredded. The pharmacist and technicians had completed the Centre for Post-graduate Pharmacy Education (CPPE) Level 2 training programme on safeguarding vulnerable adults and children, and the team were aware of things to look out for which may indicate a safeguarding issue. The team were happy to refer to the pharmacist if they suspected a safeguarding incident. The pharmacy team were all Dementia Friends and had completed this learning online. The team displayed the safeguarding policy in the dispensary and held a list of the local safeguarding contacts in the pharmacy which they could refer to if required.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough staff to manage its workload. It makes sure its team members are appropriately trained for the jobs they do. They complete regular additional training to help them keep their knowledge up to date. They can use their professional judgement to decide whether it is safe to supply medicines.

Inspector's evidence

During the inspection, there were three pharmacists, two registered technicians, two dispensers and three medicines counter assistants. The staff were seen to be working well together and supporting one another. The team also had a pre-registration pharmacist who was completing the NPA training programme and attended regular study days tailored around clinical areas in preparation for the pre-registration exam.

The team completed GPhC accredited training courses and received the Counter Skills training books from Alliance and reading material around any new products or health campaigns. The team explained that they had recent completed training on children’s oral health which was part of the new national health promotion campaign.

The pharmacy team explained that they were able to raise anything with one another whether it was something which caused concern or anything which they believed would improve service provision. There were no targets in place and the team explained that they would never compromise their professional judgement for business gain.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy's premises are clean, tidy and suitable for the provision of its services. The premises are well maintained, and they are secure when closed. Pharmacy team members use a private room for sensitive conversations with people to protect their privacy.

Inspector's evidence

The pharmacy was based on the ground floor of the building and included a retail area, medicine counter, consultation room, dispensary, stock room and staff bathrooms. The pharmacy was laid out with the professional areas clearly defined away from the main retail area of the pharmacy. The medicine counter was protected from the public by a barrier. All the products for sale within the pharmacy area were healthcare related and relevant to pharmacy services.

The pharmacy was professional in appearance and clean from the public view. The team explained that they cleaned the pharmacy between themselves every day in the morning and a cleaning rota was available. The shelves were cleaned when the date checking was carried out.

The dispensary was suitably screened to allow for the preparation of prescriptions in private. Conversations in the consultation room could not be overheard and the consultation room included seating and a sharps bin. The ambient temperature was suitable for the storage of medicines and regulated by an air conditioning system. Lighting throughout the store was appropriate for the delivery of pharmacy services.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy delivers its services in a safe and effective manner, and people with a range of needs can access them. The pharmacy sources, stores and manages medicines safely, and so makes sure that the medicines it supplies are fit for purpose. Team members identify people supplied with high-risk medicines so that they can be given any extra information they may need to take their medicines safely. The pharmacy responds satisfactorily to drug alerts or product recalls so that people only receive medicines or devices which are safe for them to take.

Inspector's evidence

Pharmacy services were displayed in the window of the pharmacy. There was a range of leaflets available to the public about services on offer in the pharmacy and general health promotion in the retail area of the pharmacy and in the consultation room. There was step-free access into the pharmacy and the team explained that they provided a delivery service for housebound patients and patients who had difficulty accessing the pharmacy. There was also seating available should a patient require it when waiting for services.

The team explained that they had a lot of batch dispensing prescriptions which were dispensed off-site within the same company. They explained that they labelled the prescriptions and the driver delivered them to their Maidenhead hub for dispensing. When this was complete, the drivers delivered them back and any prescriptions which had queries on them were highlighted. The team members were aware of the requirements for women in the at-risk group to be on a pregnancy prevention programme if they were on valproates and they had identified patients who were affected by this. The pharmacist had spoken to the affected patients and they had worked with the clinical pharmacist in the surgery next door to ensure the patients were fully informed of the risks. The team explained that they use valproate information cards and leaflets every time they dispense valproates. The pharmacist explained that if she handed out a warfarin prescription, she checked with any patients taking warfarin to ensure they were aware of their dosages and they were having regular blood tests. However, this information was not routinely recorded unless during an MUR. Dispensing labels were seen to have been signed by two different people indicating who had dispensed and who had checked a prescription.

The team were compliant with the EU Falsified Medicines Directive (FMD) and they demonstrated how they were using this to decommission medicines. The pharmacy obtained medicinal stock from Alliance, AAH, Doncaster, Phoenix, Colorama, Sigma and Berkshire Wholesale (company owned). Invoices were seen to verify this. Date checking was carried out every three months and the team highlighted items due to expire with coloured stickers. There were denaturing kits available for the destruction of controlled drugs and dedicated bins for the disposal of waste medicines were available and seen being used for the disposal of medicines returned by patients. The team also had a bin for the disposal of hazardous waste and a list of hazardous waste medicines was available in the SOPs. The fridges were in good working order and the stock inside was stored in an orderly manner. The CD cabinets were appropriate for use and expired, patient-returned CDs and CDs ready to be collected were segregated from the rest of the stock. MHRA alerts came to the team via email and they were actioned appropriately. The team kept an audit trail for the MHRA recalls and had recently actioned a recall for ranitidine tablets. The recall notices were printed off in the pharmacy and annotated to show the action

taken.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs for the delivery of its services. It looks after this equipment to ensure it works and is accurate.

Inspector's evidence

There were several crown-stamped measures available for use, including 100ml, 50ml and 10ml measures. Amber medicine bottles were seen to be capped when stored and there were clean counting triangles available as well as capsule counters. Up-to-date reference sources were available such as a BNF and a BNF for Children as well as other pharmacy textbooks. Internet access was also available should the staff require further information sources and the team could also access the NPA Information Service. The computers were all password protected and conversations inside the consultation could not be overheard.

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.