General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Mossley Pharmacy, 18 Biddulph Road, Mossley, CONGLETON, CW12 3LG

Pharmacy reference: 1090362

Type of pharmacy: Community

Date of inspection: 24/09/2019

Pharmacy context

This is a community pharmacy on the outskirts of town. The pharmacy sells over-the-counter medicines and it dispenses NHS and private prescriptions. It supplies medicines in multi-compartment compliance packs to people living at home and in care homes. And it makes deliveries of medicines to people's homes. It provides a range of services including seasonal flu vaccinations, medicines use reviews (MURs) and new medicines service (NMS).

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 has sufficient procedures to help identify and manage the risks with its services. It mostly keeps the records it must by law. And it asks people to provide feedback on its services. The pharmacy team knows how to help protect the welfare of children and vulnerable people. And the team records and discusses mistakes that happen during dispensing. This means the team members can learn from their mistakes. The team members know the importance of keeping people's private information secure. But they don't always use this knowledge to fully protect people's private information. So, some people's details may on occasions be visible to others.

Inspector's evidence

The pharmacy had a set of standard operating procedures(SOPs). Some implementation dates were from 2015 and a more recent set from 2017 (version2). Both sets appeared to be in use. Some details in version2 of the SOPs required manual additions, and not all of these had been completed. For example, safeguarding contact details. And some details in the SOPs did not completely match the processes in the pharmacy. For example, the compliance pack dispensing SOP detailed the use of dispensing labels, but the pharmacy used printed backing sheets. The superintendent pharmacist acknowledged the SOPs needed to be reviewed and updated. The pharmacy did have an up-to-date SOP for the flu vaccination service. And it had records of team members reading and signing to confirm understanding. These dated from 2010 to 2019 as new team members had started they had read the SOPs.

The pharmacy kept a paper log of near miss errors. But there was no section to record what the actual error was, for example, what had been prescribed and what had been dispensed. So, the team had documented what medicine had been involved in the error but not the details of the actual error. This limited the team's learning and the usefulness of trend analysis. The opportunity for additional learning was discussed with the pharmacist. And how documenting more information could also assist in understanding the cause of the error and help looking for trends. From the near miss error records viewed for Sept 2019 the action taken was often recorded as 'corrected mistake.' A subsequent discussion included what actions could be taken to reduce the risk of errors in the future. The pharmacist then demonstrated how the team had separated different strengths of bendroflumethiazide tablets following selection errors with only one strength being placed in the fast mover's section. The pharmacy team had also highlighted look-like and sound-alike (LASA) medicines with stickers on the dispensary shelves. And other stickers highlighted the phonetic wording of atenolol and amitriptyline.

The pharmacy reported dispensing errors that had reached the patient on a patient safety incident report form. And the team reported on to the National Reporting and Learning system (NRLS). The pharmacy had a separate form for the team to complete to keep for the pharmacy records. This form had a section to record patient details, for completeness and in case of queries. The pharmacy completed these forms when there was an error. But of the three reports viewed two didn't have full details completed, so the records didn't state the medication involved in the error. The third one was fully complete.

The pharmacy team members were clear about their roles and responsibilities. The pharmacist displayed her RP notice. The pharmacy had a task matrix to determine team members roles and responsibilities. But this had not been completed. During the inspection team members were seen

completing tasks relevant to their role and within their capabilities. The pharmacist supported the team members with their tasks and they referred queries to the pharmacist appropriately. The pharmacist referred a person to their doctor after asking appropriate questions regarding an ear infection.

The pharmacy asked for people's views of how it provided its services through an annual 'Community Pharmacy Patient Questionnaire'. The results of 2017-2018 were on view in the form of a summary bar chart. But there were no details of action taken to improve services. The pharmacy didn't have any leaflets or posters in the retail area with details of how to complain or provide feedback. The pharmacist described how any concerns were escalated to her.

The pharmacy had up-to-date professional indemnity insurance. But an out of date certificate was on display. The updated certificate was printed during the inspection. Entries in the RP record mostly complied with requirements. But the superintendent pharmacist didn't always sign out of the record at night when her RP duties ceased. This was discussed during the inspection. The sample of the CD register examined was mostly compliant with legal requirements. Headings were completed, and any alterations annotated. But the team didn't always add the address when writing in the details of the wholesaler. The pharmacy maintained running balances in the register. And it regularly checked most of these balances against physical stock. For items dispensed regularly the balance check had been completed within the last two weeks. But for rarely used items the checks were less frequent, for example the stock of Matrifen 25mcg patches had been checked in June 2019 then August 2019. A physical balance check of Matrifen 75mcg patches and Diamorphine 10mg ampoules matched the balances in the register. The pharmacy maintained a CD destruction register for patient returned medicines. And it was complete with witness signatures. The pharmacy kept complete records for private prescriptions. The pharmacy held certificates of conformity for unlicensed specials. And most were completed as required. But the pharmacy purchased an unlicensed product for a repeat prescription and this was not completed fully each time.

The pharmacy had an Information Governance SOP and it had submitted its annual NHS data security and protection (DSP) toolkit as required. It had a code of confidentiality conduct document that team members read and signed to confirm understanding. This had been updated in 2017 and so was due for review in August 2019. But the team displayed some supplier passwords on the wall in the consultation room. This was highlighted during the inspection and the pharmacist noted to remove them. The pharmacy team kept confidential waste separate and shredded it on site. But there were some prescription tokens awaiting shredding being stored in the consultation room. The consultation room was positioned behind the pharmacy counter so was no risk of unauthorised access. But there was a risk that people using the consultation room may see other people's information on these prescriptions. The pharmacy didn't have a privacy policy or any information describing to people how their private data was stored and used.

The pharmacy displayed local safeguarding contact details. And the pharmacist had completed Level 2 safeguarding training with CPPE. The team was aware of its role to help protect the welfare of children and vulnerable people. The pharmacist described some scenarios that she would escalate to the surgery or the local safeguarding teams.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough people with the right qualifications and skills to provide its services. The pharmacist helps the team members in-training. And the team members feel supported in their roles. They work in an open and honest environment, happy to discuss any mistakes they make. And they feel comfortable to raise any concerns and to feedback their ideas about the pharmacy. They can use their professional judgement and know when to refer queries to the pharmacist.

Inspector's evidence

The superintendent pharmacist was working as the RP on the day of the inspection. And supporting her was a full-time pre-registration pharmacist and a full-time trainee medicine's counter assistant/dispenser. Not working on the day, but also employed were a full-time dispenser, a part-time pharmacy technician, a part-time medicines counter assistant and a full-time driver. The pharmacist organised the staffing rota. The team members covered each other's holidays and absence. It helped as two team members were part time. The pharmacy used regular locums to cover the RP role, this helped with continuity. The pharmacy team was observed managing the workload and answering queries from people on the telephone and in the shop. When discussing sales of co-codamol over-the-counter (OTC) a team member demonstrated the relevant questions to ask and what advice she would proactively give, such as only take the tablets for 3 days. She described how to refer concerns such as too frequent requests to the pharmacist.

The team member in training had been enrolled on the Buttercups course for medicines counter assistant and dispensing training. She had been working in the pharmacy since May and had completed several modules. She was seen to be dispensing competently. And also referring to the pharmacist when a person requested OTC advice. She felt supported in her role and comfortable to discuss any training needs she had. The pre-registration pharmacist described the range of training she had been able to access over the year to help with their learning, including enrolment on Buttercups additional training. The pharmacist and pre-registration pharmacist had regular 1-2-1 discussions to support her in her learning and identify any training needs. The pharmacist completed training relevant to the services she provided. And she kept the team up to date with any changes in regulations and other pharmacy related news.

The pharmacy team communicated informally with each other and feedback was provided day to day whilst working. The superintendent pharmacist shared learning from dispensing incidents and near miss errors with the team to promote learning. The team members openly discussed mistakes they had made. And they felt comfortable raising concerns and putting ideas forward to the superintendent pharmacist or the owner. No examples of improvement ideas adopted were given. The superintendent discussed how she set her own targets to provide services to help promote people's health.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is secure, and suitably clean and tidy. It offers an appropriate space for the services provided. And it has a room, so people can have conversations with the team in private.

Inspector's evidence

The pharmacy was relatively clean, tidy and professional in appearance. Although the consultation room could have been cleaner and tidier. The pharmacy had a clean toilet for staff use and handwashing facilities with hot and cold running water. But some of the pharmacy's used pharmaceutical waste bins were stored in the toilet. The appropriateness of this was discussed during the inspection. The pharmacy had adequate heating and lighting arrangements. The layout of the premises and the bench space was adequate for the services provided. As the daily dispensing workload was completed the back bench area became full of baskets awaiting checking and meant some baskets were then stored on the floor.

The pharmacy had a consultation room situated behind the pharmacy counter. The door wasn't locked but due to its positioning there was no risk of unauthorised access. The room could have portrayed a more professional image. There was some paperwork slightly cluttering the room. The room had a door into the dispensary and this was kept open during the inspection. Although the pharmacist explained this would be closed during a consultation to prevent people's conversations being overheard in the dispensary.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy advertises its services and makes them accessible to people. It safely manages its services using suitable processes and audit trails. It organises and monitors the supply of medicines in multi-compartment compliance packs well. The team makes sure people receive these medicines when they need them. And it provides people with relevant advice and written information. The pharmacy has a well-organised medicines delivery service. It asks people to sign for the receipt of their medicines. So, the team can easily resolve queries. The pharmacy sources, stores and manages its medicines appropriately.

Inspector's evidence

There was a slight step up into the pharmacy and people accessed it through a power-assisted door. The pharmacy displayed its opening hours and the services it provided in the window. And it displayed a range of leaflets in the retail area, including ones for local services and national health promotion campaigns. The pharmacy provided some seating for people waiting for prescriptions and services.

The pharmacy had separate allocated areas in the dispensary for labelling, assembly and checking. As the team members completed the daily dispensing workload during the inspection, they stored some baskets with prescriptions and medication on the floor as the bench space was tight. This was only as the number of prescriptions awaiting checking increased. The pharmacist indicated this was unusual as she would normally be checking the prescriptions as they were dispensed. The pharmacy had dispensed by and checked by boxes on the dispensing labels. The team members initialled the boxes as part of the dispensing process. And evidence of this was seen on prescriptions awaiting checking. The pharmacy delivered medicines to people's homes. To help identify those people who required their medicines delivered the word 'delivery' was printed on the name and address bag labels. This reduced the risk of these prescriptions being placed in the retrieval area once checked. The pharmacy kept a record of the medicines it delivered. And it asked people to sign for receipt of their medicines. The pharmacy obtained verbal consent for delivery to a different address but didn't make a record of this consent. The team had an awareness of the specific requirements of the valproate pregnancy prevention programme (PPP). And the cards and stickers associated with the programme had been used after the publication of the safety alert. But the team had stopped providing written information since the original manufacturer's packs were updated with the warnings and the pack size had changed. She confirmed she would order a replacement pack. The pharmacist described how she would give relevant advice and refer people taking valproate to the surgery if required. The pharmacist described how she asked for the details of people's last blood test if they were taking warfarin. And how the surgery required the blood tests results before issuing a prescription. But the records on a person's patient medication records (PMR) she demonstrated were from 2017.

The pharmacy was prepared for providing flu vaccinations. The stock arrived on the day of the inspection. The pharmacist had leaflets on the table in the consultation room. And had placed a sharps bin and an in-date Epipen in the consultation room. The pharmacist had completed the required training and the pharmacy had an up-to-date service specification. A person requested a flu vaccination during the inspection. And the required paperwork was completed prior to the vaccination.

The pharmacy dispensed medicines into multi-compartment compliance packs for people living in the

community and in three care homes. It documented information relating to the dispensing of these packs on a notice board. The team separated the dispensing of the community packs into four weeks to spread the workload more evenly. And it kept a list of which week the people received their packs. The pharmacy ordered prescriptions for people receiving community compliance packs the week prior to people needing them. This meant that the team had enough time to resolve queries and dispense the medicines into the packs. The team used a log to monitor the progress of the prescription ordering and dispensing of these packs. This helped to make sure the packs were delivered to people before they were needed. Each person receiving compliance packs had a master record card detailing the medicines they were currently taking. And the times they would take them. When medication was changed or stopped the team member updated the master record card and dated the change. The team used the prescription and the record card when dispensing and checking the packs. And descriptions of what the medicines looked like were added on to the pack, so people could identify their medicines. And the team sent patient information leaflets (PILs) with the packs once a month. This was observed on a compliance pack awaiting delivery. The pharmacist visited each care home once a year to provide advice, for example on the safe storage of medicines. During the visit, care home staff could provide feedback on the pharmacy's services.

The pharmacy stored its Pharmacy (P) medicines behind the pharmacy counter to prevent self-selection and allow intervention by the pharmacist if needed. It stored cold chain medicines in a medical fridge, in baskets and in an organised manner. The fridge was of an appropriate size. Of the sample checked, the pharmacy had recorded the fridge temperatures as between two and eight degrees Celsius. But there had been one occasion when the fridge temperature had been above the maximum recommended temperature. When re-checked the temperature had been in range. But some of the team hadn't known how to reset the thermometer and so the readings showed the maximum out of range until reset. The fridge temperature records kept therefore didn't match the maximum and minimum on the thermometer during this time. The pharmacist agreed the team had a training need. There was a discussion about the importance of accurate recording.

The pharmacy purchased its medicines from licenced wholesalers such as AAH and Alliance. A pharmacy team member described how they checked the expiry dates of its medicines regularly, but the pharmacy didn't keep a record. Of a sample checked one out-of-date medicine was found on the dispensary shelves. On checking further no more out-of-date medicines were found. The team used short-dated stickers when completing the date checking process. Several stickers were seen on manufacturer's packs on the shelves. These packs had expiry dates ranging from October 2019 to January 2020. The pharmacy had scanners to comply with the falsified medicines directive (FMD) and had registered with SecurMed. But the team hadn't planned when to start scanning and decommissioning. The pharmacy had medical waste bins, sharps bins and CD denaturing kits available to support managing pharmaceutical waste. The pharmacy received alerts about recalls and safety alerts. The team actioned them appropriately.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs to provide its services. And it generally uses them in a way to protect people's confidentiality.

Inspector's evidence

The pharmacy had up-to-date reference resources such as the BNF, BNF for children and Stockley's interactions reference book. The team could also access the internet to resolve queries and obtain up-to-date clinical information. The pharmacy had a range of clean, crown-stamped glass measures stored near the sink in the dispensary. It had equipment available for the services it provided, including single-use consumables for compliance pack dispensing. The pharmacy tested its electrical equipment. The last test date had been in February 2018.

The pharmacy had a computer on the pharmacy counter, with access to people's medication records (PMR). The screen was positioned so people at the pharmacy counter couldn't see people's private details on the screen. Some people's prescriptions awaiting collection were stored in totes just behind the pharmacy counter, but level with shelves in the shop. There was a risk that people's name and addresses on the pharmacy bag labels could be seen by people at the pharmacy counter. And that people could pick the medicines bags from the totes. The pharmacist described how the prescription storage had recently changed. She confirmed she would review the storage again following the inspection. The pharmacy had cordless telephones, which allowed the team to have conversations with people in private.

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.