General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Greenfields Pharmacy, 7 New Shop Parade, Greenfield Road, Greenfield, HOLYWELL, Clwyd, CH8 7QS

Pharmacy reference: 1090526

Type of pharmacy: Community

Date of inspection: 09/12/2019

Pharmacy context

The pharmacy is situated amongst a small number of other retail shops in Greenfield, near the town of Holywell in North Wales. The pharmacy premises are accessible for people, with adequate space in the retail area. It has a consultation room available for private conversations. The pharmacy sells a range of over-the-counter medicines and dispenses private and NHS prescriptions. And it supplies medication 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 has written procedures to help make sure the team provide services effectively. And it protects peoples' information. Members of the pharmacy team are clear about their roles and responsibilities. And they record some things that go wrong. But they do not record or review all of their mistakes, so they may miss some opportunities to learn. The pharmacy keeps the records required by law, but some information is missing, which could make it harder to understand what has happened if queries arise.

Inspector's evidence

There were up-to-date standard operating procedures (SOPs) for the services provided, with sign off sheets showing that members of the pharmacy team had read and accepted them. Roles and responsibilities of the pharmacy team were set out in SOPs. A member of the pharmacy team was able to clearly describe her duties.

Dispensing incidents were recorded on incident report forms, which were reviewed by the superintendent (SI). Near miss errors were discussed with the member of the pharmacy team at the time and some were recorded in the near miss log. There were no near miss errors recorded on several months in the last year and no evidence the near misses that were reported had been reviewed.

The correct responsible pharmacist (RP) notice was displayed conspicuously in the pharmacy. A complaints procedure was in place and a practice leaflet was available in the retail area explaining the complaints process. The pharmacist explained that he aimed to resolve complaints in the pharmacy at the time they arose. A customer satisfaction survey was carried out annually. A dispenser explained that some patients had provided negative feedback about the stock availability. She said the pharmacy had a good working relationship with the local GP practice and the GPs would change the medication prescribed when there were long-term manufacturing problems.

Insurance arrangements were in place. And a current certificate of professional indemnity insurance was displayed. The private prescription record, emergency supply record and the CD register were in order. Records of CD running balances were kept and audited regularly. A balance check for a random CD was carried out and found to be correct. Patient returned CDs were recorded and disposed of appropriately. The responsible pharmacist (RP) record was up-to-date but had the time the RP ceased their duty missing on most occasions. The unlicensed specials record had the patient details missing from some records.

Confidential waste was placed into a bag and collected by an authorised carrier. Confidential information was kept out of sight of patients and the public. An information governance policy was in place and all staff had read and signed confidentiality agreements as part of their employment contracts. The computer was password protected, screens were positioned so that they were facing away from customers and assembled prescriptions awaiting collection were stored so that patient information was not visible. A privacy notice was displayed.

The pharmacist had completed level 2 safe guarding training and all staff had read the safeguarding policy. There were no details of local safeguarding contacts present, which may make it more difficult

for the team in the event of a concern arising.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough staff to manage its workload safely. The team members are comfortable about providing feedback to the pharmacist. But the lack of formal ongoing training could mean their skills and knowledge may not always be up to date.

Inspector's evidence

There was a pharmacist manager, two dispensers and a medicines counter assistant on duty. The dispensers and the medicines counter assistant had completed accredited training courses for their roles, with their certificates displayed. The staff were busy providing pharmacy services. They appeared to work well together as a team and manage the workload adequately.

A member of the pharmacy team spoken to said the pharmacist was supportive and was more than happy to answer any questions they had. She explained that apart from reading updated SOPs, no ongoing training material was provided. The pharmacy team were aware of a process for whistle blowing and knew how to report concerns if needed. Members of the pharmacy team had received an appraisal with the pharmacist in the last year. And they were also provided with information informally from the pharmacist.

The medicines counter assistant was clear about her role. She knew what questions to ask when making a sale and when to refer the patient to a pharmacist. She was clear which medicines could be sold in the presence and absence of a pharmacist and was clear what action to take if she suspected a customer might be abusing medicines such as co-codamol, which she would refer to the pharmacist for advice. The pharmacist explained that there was a target in place for MURs but said he had not felt under any pressure to achieve this.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is generally clean and tidy. It is a suitable place to provide healthcare. It has a consultation room so that people can have a conversation in private.

Inspector's evidence

The pharmacy was generally clean and tidy. It was free from obstructions and had a waiting area. A dispenser said that dispensary benches, sink and floors were cleaned regularly, but no record was kept. The temperature in the pharmacy was controlled by heating units. Lighting was good.

The pharmacy premises were maintained and in an adequate state of repair. Pharmacy team facilities included a microwave, kettle, toaster, WC with wash hand basin and antibacterial hand wash. There was a consultation room available which was uncluttered and clean in appearance.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's services are accessible to most people and they are generally well managed, so people receive their medicines safely. But members of the pharmacy team do not always know when high-risk medicines are being handed out. So, they may not always make extra checks or give people advice about how to take them. The pharmacy carries out some checks to help make sure that stock medicines are in good condition. But some have been repackaged which could cause errors to happen.

Inspector's evidence

The pharmacy, consultation room and pharmacy counter were accessible to all, including patients with mobility difficulties and wheelchairs. There was a selection of healthcare leaflets. The pharmacy team were clear about what services were offered and where to signpost to services they did not provide. The opening hours were displayed near the entrance.

The work flow in the pharmacy was organised into separate areas, with a designated room upstairs for the care home service, adequate dispensing bench space and a checking area for the pharmacist. Baskets were used in the dispensary to separate prescriptions to reduce the risk of medicines becoming mixed up during dispensing.

A member of the pharmacy team demonstrated that prescriptions containing schedule 2 CDs had a CD sticker included on the assembled bag. She explained that this was to act as a prompt for staff to take the CD from the CD cabinet and include it with the rest of the assembled prescription at the time of supply. She said prescriptions containing tramadol or pregabalin had the prescription attached to the assembled bag to act as a prompt when handing out, but prescriptions containing other schedule 3 and 4 CDs were not highlighted, which may increase the possibility of supplying a CD on a prescription that had expired.

A member of the pharmacy team explained that prescriptions with high-risk medicines such as warfarin, methotrexate or lithium were not routinely highlighted prior to collection. The team was aware of the risks associated with the use of valproate during pregnancy. A pharmacist had carried out an audit of patients prescribed valproate and had not identified any patients who met the risk criteria. The pharmacy had patient information resources available to supply with valproate.

The pharmacy provided medicines in multi-compartment compliance aids to a number of community patients and provided medicines in single-compartment compliance aids for people in care homes. A dispenser provided a detailed explanation of how the multi-compartment compliance aid service was managed. Details of any changes to medication were added to the computer patient medication record (PMR). Disposable equipment was used and individual medicine descriptions were included on the labels. Patient information leaflets were not included with each supply. So, people may not be provided with the most up-to-date information about their treatment. The care home service was well organised with the medication for different care homes dispensed in a timely manner to ensure that the residents received their medication when required. Patient information leaflets were included with the assembled medication for care homes. A dispenser explained that the care homes were responsible for ordering their residents prescriptions from the GP practice and double checking that the prescriptions they received back were accurate, prior to them being sent to the pharmacy for dispensing. The

pharmacy produced medicine administration record (MAR) charts for the care home residents, which were cross checked for accuracy prior to being sent out with the medication.

Stock medicines were sourced from licensed wholesalers and specials from a licensed manufacturer. Stock was generally stored tidily. But, a small number of medicines had been removed from their original packaging and placed into capped bottles or cardboard containers that had no batch number or expiry date details. This did not meet labelling requirements and increased the risk of error. The pharmacist provided assurance that this was not usual practice and these medicines were going to be disposed of.

Date checking was carried out approximately every six months and a record was kept. No out-of-date stock medicines were found present from a number that were sampled. CDs were stored appropriately. Patient returned CDs were destroyed using denaturing kits and a record was kept. There were two clean fridges used to store medicines, both equipped with thermometers. The minimum and maximum temperatures were being recorded daily and the records were complete.

The pharmacy team were aware of the Falsified Medicines Directive (FMD). The pharmacy had a 2D barcode scanner installed at the computer terminal, but the team had stopped using the FMD software installed after having problems with it. Therefore, the pharmacy was not complying with legal requirements. Alerts and recalls were received via email from head office and notifications from the wholesalers. These were actioned on by the pharmacist or pharmacy team member and a record was kept. The pharmacy was not registered with the MHRA to receive notifications of alerts or recalls, which may increase the possibility of not receiving or actioning a notification in a timely manner.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide services safely. It is used in a way that protects privacy. And electrical equipment is regularly tested to make sure it is safe.

Inspector's evidence

The pharmacy had copies of the up-to-date BNF and BNFc. The pharmacy team used the internet to access websites for up to date information. For example, Medicines Complete. Any problems with equipment were reported to the pharmacist. All electrical equipment appeared to be in working order and had been PAT tested in November 2018.

There was a selection of liquid measures with British Standard and Crown marks. The pharmacy had equipment for counting loose tablets and capsules, including tablet triangles. The computer was password protected with the screen positioned so that it wasn't visible from the public areas of the pharmacy.

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.