General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Eggborough Pharmacy, 87 Selby Road, Eggborough, GOOLE, North Humberside, DN14 0LJ

Pharmacy reference: 1090750

Type of pharmacy: Community

Date of inspection: 06/11/2019

Pharmacy context

This community pharmacy is next door to a small GP surgery in the village of Eggborough. The pharmacy dispenses NHS and private prescriptions. The pharmacy supplies multi-compartmental compliance packs to help people take their medicines. And it delivers medication to people's homes. The pharmacy provides a supervised methadone service.

Overall inspection outcome

Standards not all met

Required Action: Improvement Action Plan

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 not all met	1.2	Standard not met	The pharmacy team members do not regularly record the errors they make whilst dispensing. They have not recorded any near miss errors for over 12 months. And they cannot evidence any reports of dispensing errors that have reached the person. This does not allow effective learning from their mistakes. And the team does not have information to review dispensing errors and identify patterns. So, it may be difficult to take appropriate action to prevent similar errors from happening again.
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 not all met**

Summary findings

The pharmacy team mostly identifies and manages the risks associated with its services. But the team members do not regularly record the errors they make during dispensing. They have not recorded any near miss errors for over a year. And the team members cannot evidence any reports of dispensing errors when the medicine has reached the person. So, the team does not have information to review dispensing errors and identify patterns. And it is difficult for the team to take appropriate action to help prevent similar errors from happening again. The pharmacy team has some level of training and guidance to respond to safeguarding concerns to protect the welfare of children and vulnerable adults. People using the pharmacy can raise concerns and provide feedback. The pharmacy has written procedures that the pharmacy team follows. But not all the procedures have been recently reviewed. This means there is a risk that team members may not be following up-to-date procedures. The pharmacy keeps most of the records it needs to by law.

Inspector's evidence

The pharmacy had a range of standard operating procedures (SOPs). The SOP covering information governance and the SOP on pharmacy intervention and problem solving were copies of the SOPs produced by another pharmacy company. This means there may be information in the SOPs that is not relevant to how this pharmacy operates. These SOPs were dated 2012 and had no evidence of a review. Most of the SOPs were reviewed in 2018 by the pharmacist who previously worked at the pharmacy. And a few SOPs did not have evidence of a review. For example, the SOP covering the handling out of prescriptions had a date of May 2014 but no review. The SOP for the methadone service had a date of March 2015 but no evidence of a review. The SOP for handling complaints had no dates of preparation or review. So, the team would not know if they were following up-to-date procedures. Most of the team had signed the SOPs signature sheets to say they'd read, understood and would follow the SOPs. The dispenser had signed the SOPs signature sheets at another company in the pharmacy. But had not signed the sheets for this pharmacy when they moved to work at the pharmacy full-time. The pharmacy had up-to-date indemnity insurance.

The pharmacist when checking prescriptions and spotting an error sometimes asked the team member involved to find and correct the mistake. So, not every opportunity was taken for the team member to reflect on their own error. The pharmacy had a template to record these near miss errors. But the team could not easily locate the near miss records. And when the team found the records they showed the last entries were made in September 2018. The records completed by the team had limited information. The team did not detail what had been prescribed and dispensed to spot patterns. And team members did not always record what caused the error, their learning from it and actions they had taken to prevent the error happening again. When the team did record this information, the details captured were often the same. For example, incorrect selection of a product and the action taken was recorded as 'changed' rather than how the team member could prevent the same error happening again. The pharmacy did not review the near miss error reports to spot patterns and make changes. But the team had separated ramipril tablets and capsules to reduce the risk of picking the wrong formulation. The pharmacy had a template to record dispensing errors. These were errors that were identified after the person had received their medicines. The team stated there had not been a dispensing error for some time. But they could not locate any completed reports.

The pharmacy had a procedure for handling complaints raised by people using the pharmacy. And it had a leaflet providing people with information on how to raise a concern. But this was not displayed in the retail area for people to see. There was no other information source such as a poster. The pharmacy team used surveys to find out what people thought about the pharmacy. The pharmacy published these on the NHS.uk website.

A sample of controlled drugs (CD) registers looked at found that they met legal requirements. The pharmacy did not regularly check the CD stock against the balance in the register. For example, the CD register for fentanyl 37.5 patches showed the last entry was 15 January 2019. So, the team did not have information to spot errors such as missed entries. A balance check of Zomorph 30mg found it matched the quantity in the CD register. The pharmacy recorded CDs returned by people. A sample of Responsible Pharmacist records looked at found that they met legal requirements. A sample of records of private prescription supplies found that the prescriber's details were not always correct. A sample of records for the receipt and supply of unlicensed products looked at found that they met the requirements of the Medicines and Healthcare products Regulatory Agency (MHRA). Some of the team had received training on the General Data Protection Regulations (GDPR). The pharmacy displayed a privacy notice in line with the requirements of the GDPR. The team separated confidential waste for shredding offsite.

The pharmacy had some safeguarding information to use if they had a concern. And the team members had access to contact numbers for local safeguarding teams. The pharmacist and pharmacy technician had completed level 2 training from the Centre for Pharmacy Postgraduate Education (CPPE) on protecting children and vulnerable adults. The team had completed Dementia Friends training. The team had not had the occasion to report a safeguarding concern.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has a team with the qualifications and skills to support the pharmacy’s services. The team members discuss how they can make improvements. And they generally implement changes to support the safe and efficient delivery of these services. The pharmacy team members do not regularly receive feedback on their performance. And they don't have opportunities to complete ongoing training. So, they may not keep their skills and knowledge up to date.

Inspector's evidence

Locum pharmacists covered the opening hours. The pharmacy team consisted of a full-time pharmacy technician, a full-time qualified dispenser, a part-time dispenser and three delivery drivers who worked between the two local pharmacies. The pharmacy technician had taken on some managerial duties after the full-time pharmacist left. The pharmacy technician got some support from the company head office. And had arranged with the company for the full-time dispenser to work permanently at this pharmacy after another dispenser left. The full-time dispenser had been working at this pharmacy and another pharmacy in the company. This was agreed with the full-time dispenser.

The pharmacy did not provide extra training for the team. So, they didn't have the chance to identify any training needs and maintain their knowledge and skills. The team members had not had formal feedback on their performance for some time. So, they didn't have the chance to discuss their development needs. The team members were observed competently completing their tasks. And appropriately responding to queries. Team members could suggest changes to processes or new ideas of working. The team members had found that the controlled drug (CD) and fridge stickers placed on bags and prescriptions to remind them when handing over medication to include these items often came off. So, they introduced a process of writing the first letter of the CD medicine and F for fridge items on to the bags in addition to the sticker. The pharmacy had targets for services such as Medicine Use Reviews (MURs). And the team felt the targets were achievable. The pharmacist offered the services when they would benefit people.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean, secure and adequate for the services provided. And it has facilities to meet the needs of people requiring privacy when using the pharmacy services.

Inspector's evidence

The pharmacy was clean, tidy and hygienic. It had separate sinks for the preparation of medicines and hand washing. The team kept floor spaces clear to reduce the risk of trip hazards. The pharmacy had enough storage space for stock, assembled medicines and medical devices. The pharmacy had a sound proof consultation room. The team used this for private conversations with people. The premises were secure. The window displays detailed the opening times and the services offered. The pharmacy had a defined professional area. And items for sale in this area were healthcare related.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy team members provide services that support people's health needs. And they manage the pharmacy services well. The pharmacy team members keep records of deliveries made to people's home. So, they can effectively deal with any queries. The pharmacy obtains its medicines from reputable sources. And it mostly stores and manages medicines appropriately.

Inspector's evidence

The pharmacy kept a small range of healthcare information leaflets for people to read or take away. And there were two folders in the retail area containing healthcare information. One was specifically for the health needs and medical conditions amongst children. The team had access to the internet to direct people to other healthcare services. The pharmacy supplied methadone as supervised and unsupervised doses. And it prepared the methadone doses in advance before supply. This reduced the workload pressure of dispensing at the time of supply. The pharmacy team were aware of the criteria of the valproate Pregnancy Prevention Programme (PPP). But the pharmacy did not have the PPP pack to provide people with information when required.

The pharmacy provided multi-compartmental compliance packs to help around 32 people take their medicines. People received monthly or weekly supplies depending on their needs. The pharmacy technician managed the service with support from others in the team. To manage the workload the pharmacy technician divided the preparation of the packs across the month. And usually ordered prescriptions two weeks before supply. This allowed time to deal with issues such as missing items. And the dispensing of the medication in to the packs. Each person had a record listing their current medication and dose times. The pharmacy technician checked received prescriptions against the list. And queried any changes with the GP team. The pharmacy technician usually recorded the descriptions of the products within the packs. And supplied the manufacturer’s patient information leaflets. The team bagged the weekly packs separately awaiting supply. And wrote the date of supply on the label and the week number. The team sometimes received information about medicine changes after people were discharged from hospital.

The team members provided a repeat prescription ordering service for two people who could not manage the ordering of their prescriptions. The person contacted the pharmacy team to order the medicines for their repeat prescription. The team usually ordered the prescriptions a week before supply. This gave time to chase up missing prescriptions, order stock and dispense the prescription. The pharmacy provided separate areas for labelling, dispensing and checking of prescriptions. The pharmacy team used baskets when dispensing to hold stock, prescriptions and dispensing labels. This prevented the loss of items and stock for one prescription mixing with another. The pharmacy used controlled drugs (CD) and fridge stickers on bags and prescriptions to remind the team when handing over medication to include these items. The pharmacy had a system to prompt the team to check that supplies of CD prescriptions were within the 28-day legal limit. The pharmacy had checked by and dispensed by boxes on dispensing labels. These recorded who in the team had dispensed and checked the prescription. A sample looked at found that the team completed the boxes. When the pharmacy didn’t have enough stock of someone’s medicine, it provided a printed slip detailing the owed item. And kept a separate one with the original prescription to refer to when dispensing and checking the remaining quantity. The pharmacy kept a record of the delivery of medicines to people. This included a

signature from the person receiving the medication.

The pharmacy team had completed a check of the expiry dates on stock the previous month. But it had no record available of this. The team used a coloured dot to highlight medicines with a short expiry date. No out of date stock was found. The team sent short-dated stock to head office. So, these medicines could be distributed to other pharmacies in the company who may use the medicines before they went out of date. The team members usually recorded the date of opening on liquids. This meant they could identify products with a short shelf life once opened. And check they were safe to supply. The team recorded fridge temperatures each day. A sample looked at found they were within the correct range. The pharmacy had medicinal waste bins to store out-of-date stock and patient returned medication. And it stored out-of-date and patient returned controlled drugs (CDs) separate from in-date stock in a CD cabinet that met legal requirements. The team used baskets to separate CD stock. The team used appropriate denaturing kits to destroy CDs.

The pharmacy computer had a programme that met the requirements of the Falsified Medicines Directive (FMD). But the pharmacy had no scanning equipment to meet FMD requirements. And the team hadn't received any FMD training. The pharmacy obtained medication from several reputable sources. And received alerts about medicines and medical devices from the Medicines and Healthcare products Regulatory Agency (MHRA) via email. The team printed off the alert, actioned it and kept a record.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide safe services and protect people's private information.

Inspector's evidence

The pharmacy had reference sources and access to the internet to provide the team with up-to-date clinical information. The pharmacy used a range of CE equipment to accurately measure liquid medication. And used separate, marked measures for methadone. The pharmacy had a fridge to store medicines kept at these temperatures. And it used baskets to separate medicine stock in the fridge. The team stored completed prescriptions for fridge medicines on a dedicated shelf in the fridge. So, the team could easily locate the medicine when the person presented. The pharmacy completed safety checks on the electrical equipment.

The computers were password protected and access to people's records restricted by the NHS smart card system. The pharmacy positioned the dispensary computers in a way to prevent disclosure of confidential information. The pharmacy stored completed prescriptions away from public view. And it held private information in the dispensary and rear areas, which had restricted access. The team used cordless telephones to make sure telephone conversations were held 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.