General Pharmaceutical Council

# Registered pharmacy inspection report

**Pharmacy Name:** Well, Freckleton Health Centre, Douglas Drive, Freckleton, PRESTON, Lancashire, PR4 1RY

**Pharmacy reference:** 1090810

**Type of pharmacy:** Community

**Date of inspection:** 05/07/2022

## Pharmacy context

This is a community pharmacy inside a medical centre with two GP surgeries. It is situated in the village of Freckleton, on the Fylde coast. There is no other pharmacy provision within the village and the next closest pharmacy is 3 miles away. The pharmacy dispenses NHS prescriptions, private prescriptions and sells over-the-counter medicines. It also provides a range of services including seasonal flu vaccinations. 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 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 met | N/A | N/A | N/A |
| **2. Staff** | Standards not all met | 2.1 | Standard not met | The pharmacy team is not managing the workload effectively, which means non-urgent tasks are not being completed. |
| **3. Premises** | Standards not all met | 3.1 | Standard not met | The pharmacy is cluttered and untidy which makes the workspace less safe and the dispensing operation less effective. |
| **4. Services, including medicines management** | Standards not all met | 4.3 | Standard not met | There are out of date medicines present on the dispensary shelves, fridge temperatures are not being properly monitored, and waste medicines are not appropriately managed. |
| **5. Equipment and facilities** | Standards met | N/A | N/A | N/A |

## Principle 1 - Governance ✔ Standards met

### Summary findings

The pharmacy team follows written procedures, and this helps to maintain the safety and effectiveness of the pharmacy's services. The pharmacy generally keeps the records it needs to by law. And members of the team are given training so that they know how to keep private information safe. They discuss things that go wrong, but incidents are not always recorded, so they may miss some learning opportunities. And there may be a risk of similar mistakes happening again.

### Inspector's evidence

There was an electronic set of standard operating procedures (SOPs) which were routinely updated by the head office. Members of the pharmacy team said they had read the SOPs, but the pharmacy manager did not have access to training records. So she could not provide assurance that members of the team had read all of the SOPs or fully understood their responsibilities.

The pharmacy had a system to record and review any near miss incidents. However, none had been recorded for some time. Members of the pharmacy team said the pharmacist would discuss any mistakes as they occurred. But there was no record to show any learning that had been identified. Members of the team understood how to record and investigate a dispensing error. But they were not aware of incidents that had been reported in the last few weeks.

Roles and responsibilities of the pharmacy team were described in individual SOPs. A trainee dispenser was able to explain what his 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 on display in the consultation room. Any complaints were recorded and followed up by the pharmacy manager. A current certificate of professional indemnity insurance was available.

Records for private prescriptions, emergency supplies and unlicensed specials appeared to be in order. Controlled drugs (CDs) registers were electronically maintained with running balances recorded. Two random balances were checked, and both found to be accurate. Patient returned CDs were recorded in a separate register. RP records appeared generally in order, except there was no RP record for 17th June 2022.

An information governance (IG) policy was available. The pharmacy team completed IG training. When questioned, a trainee dispenser was able to describe how confidential information was segregated to be removed by a waste carrier company. Information about how people's data was handled was on display within the retail area. Safeguarding procedures were included in the SOPs and the pharmacy team had completed safeguarding training. The pharmacist said he had completed level 2 safeguarding training. A trainee dispenser said he would initially report any concerns to the pharmacist on duty.

## Principle 2 - Staffing **Standards not all met**

### Summary findings

The pharmacy team has undergone recent changes in personnel which made it difficult to manage the workload and caused a backlog to build up. Although this has been addressed with extra resources, these measures were only short term. Which means the pharmacy team is still not operating effectively and less urgent tasks are not being completed.

### Inspector's evidence

The pharmacy team included a pharmacist, two pharmacy technicians, and three dispensers, one of whom was in training. All members of the pharmacy team were appropriately trained or on accredited training programmes. The usual staffing level was a pharmacist and three to four members of the team. There had been several recent changes to the pharmacy team. This included changes in branch management and leadership. The new pharmacy manager had been in post for about 4 weeks and there was no longer a regular pharmacist so multiple different locum pharmacists had been employed.

At the time of the inspection, some of the regular pharmacy team were absent and staffing levels were maintained by a relief dispenser, and a pharmacy student, who was working on a six-week placement. Members of the team had come in whilst the pharmacy was closed on the previous Sunday to catch up with outstanding dispensing work. And the following day, a 2nd pharmacist had been employed to assist in catching up on the backlog of dispensed medicines. This meant the pharmacy was now up to date with its repeat prescription dispensing. However, the new team was still struggling to manage the workload effectively and as a result the pharmacy had fallen behind with some routine tasks such as date checking, near miss recording and CD balance checks.

The pharmacy used the company's central fulfilment hub to dispense some of its repeat prescriptions. However, the pharmacy had a high footfall and a significant volume of prescriptions continued to be dispensed in the branch. The team also had to deal with a high number of medical queries from patients and customers. This involved members of the team having to stop what they were doing in order to answer the telephone, or provide additional assistance at the medicines counter to help prevent the queue becoming too long.

The pharmacy provided the team with a structured e-learning training programme. But the pharmacy manager was unable to view the progress of individual team members as she had not yet been granted access to view this information. Members of the team admitted that with their current workload they had not had enough time to complete training during working hours.

A trainee dispenser was seen selling over-the-counter medicines appropriately. When questioned, he gave examples of how he would sell a pharmacy only medicine using the WWHAM questioning technique and refer people to the pharmacist if needed. The locum pharmacist said he felt able to exercise his professional judgement and this was respected by members of the team and the area management. The relief dispenser had not worked at the pharmacy before but said he felt a good level of support from the pharmacy team, and felt able to ask for help if he needed it. Staff were aware of the whistleblowing policy and said that they would be comfortable reporting any concerns to the area manager or superintendent.

There were targets for services such as the new medicines service (NMS), and the pharmacy routinely

received email messages encouraging them to provide this service. The pharmacist said he would try his best to do this during a quieter time during the afternoon. But as the pharmacy had so much to catch up on, members of the team felt this created additional pressure and was demoralising.

## Principle 3 - Premises **Standards not all met**

### Summary findings

The pharmacy premises are suitable for the services it provides. But the dispensary is cluttered and untidy. This makes the workspace less safe and the dispensing operation less effective.

### Inspector's evidence

The pharmacy was cluttered and untidy. There were numerous boxes on the dispensary floor, which presented a tripping hazard to staff. Some of the shelves were dusty, and the sink area was untidy. The pharmacy manager said they would usually have put all the stock orders away by late morning, but they had prioritised putting retail stock away on that day because there had been a lot of boxes waiting in the retail area. Some were medicines put in the wrong places on dispensary shelves. For example, different strengths of felodipine were mixed. And trazodone 50mg capsules were found amongst tramadol 50mg capsules, which were normally kept separate to help prevent picking errors. The dispensary felt very warm, and members of the team said this was due to a maintenance issue that was affecting the air conditioning across the whole building. The pharmacy manager had purchased fans to help create some air flow within the dispensary. There was a staff area with a kettle, microwave, and separate staff fridge. However, this area was cluttered with piles of admin paperwork, retail stock, expired medicine stock and MDS blister packs, meaning there was limited space for staff to use these facilities.

Perspex screens had been installed at the medicines counter to help prevent the spread of infection. Markings were used on the floor to help encourage social distancing. Staff were wearing masks. Hand sanitiser was available.

A consultation room was available and access to it could be restricted by use of a lock. The space was generally clutter free with a desk, seating, adequate lighting, and a wash basin. A patient report with a list of names and addresses had been left on the desk, where it could be seen by anyone using the room.

## Principle 4 - Services **Standards not all met**

### Summary findings

Most of the pharmacy's services were appropriately managed to operate safely. But urgent activities had been prioritised which meant that some less urgent tasks were being neglected. This included expiry date checks of medicine stock, monitoring fridge temperatures, and processing patient-returned medicines. So the pharmacy could not provide assurance that all of its medicines had been stored appropriately or were fit for purpose.

### Inspector's evidence

Access to the pharmacy was level via a medical centre and was suitable for wheelchair users. There was also wheelchair access to the consultation room. Pharmacy branded leaflets gave information about the services offered and information was also available on the website. Pharmacy staff were able to list and explain the services provided by the pharmacy. The pharmacy opening hours were displayed and a range of leaflets provided information about various healthcare topics.

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. The baskets were colour coded to help prioritise dispensing.

Some medicines were dispensed by an automated hub as part of the company's central fulfilment programme. Prescriptions for the hub were processed at the pharmacy and each item on the prescription was marked to indicate whether it was to be dispensed locally at the pharmacy or at the hub. Before transmission to the hub, the pharmacist was required to complete an accuracy check of the computer data and a clinical check on the prescription. Some items could not be dispensed by the hub, including items out of stock, split-packs, CDs and fridge items. The system used a personal log in to show who had labelled the prescription and who had performed the accuracy check.

Dispensed medicines were received back from the hub within 24-48 hours. They were delivered in totes that clearly identified that they contained dispensed medicines. The medicines were packed in sealed bags with the patient's name and address the front. These did not need to be accuracy checked by the pharmacy unless a member of the team opened the bag, in which case the responsibility for the final accuracy check fell to the pharmacy rather than the hub. As part of the process the pharmacist was expected to check one or two bags each day to confirm the accuracy of the dispensed medicines was as expected. These checks were supposed to be recorded but this was not happening. So the pharmacy could not demonstrate that the procedure was being followed.

Some medicines were dispensed in multi-compartment compliance aids. 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, and a note was made in the communications log. 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.

Dispensed medicines awaiting collection were kept on a shelf and their location was recorded on an

electronic device. When a person came to collect their dispensed medicines, members of the team used the device to find their location. Prescription forms were retained with the dispensed medicines, 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. But the pharmacy did not have a reliable procedure to ensure any dispensed medicines which contained a schedule 3 or 4 controlled drug were supplied within the validity of the prescription. So there was a risk these medicines could be supplied when the prescription had expired. Members of the team were aware of the risks associated with the use of valproate during pregnancy. They said the pharmacist had spoken to patients who were at risk to make sure they were aware of the pregnancy prevention programme. And educational material was available to hand out when valproate was supplied.

The pharmacy had a delivery service. Deliveries were segregated after their accuracy check and recorded on an electronic device. This was used to obtain signatures from the recipient to confirm delivery. Unsuccessful deliveries would be returned to the pharmacy and a card posted through the person's letterbox indicating the pharmacy had attempted a delivery. A separate signature was obtained for any deliveries which contained a CD.

Medicines were obtained from licensed wholesalers, and any unlicensed medicines were sourced from a specials manufacturer. The expiry dates of stock medicines were supposed to be checked on a regular basis, but the checks had not been completed for some time. The pharmacy manager explained she had completed a date check of stock when she first started due to the number of out-of-date medicines she had found on the shelves. However, a spot check found several medicines present which had expired. One of these medicines had expired in December 2020, whilst others were from October 2021.

Controlled drugs were stored appropriately in the CD cabinet, with segregation between current stock, patient returns and out of date stock. There were clean medicines fridges, each with a thermometer, and the current temperature readings were within the required range. There was a record sheet to log the minimum and maximum temperature each day. However, this was rarely done with only 11 entries for each fridge in the previous 3 months. So the pharmacy may not be able to show the medicines were being stored appropriately.  Designated bins to dispose of patient returned medication or expired stock were available. But a large volume of medicines was piled on top of, and on the floor next to the bins whilst waiting to be sorted. The bins were located opposite the shelves of dispensed medicines awaiting collection, so there was a risk of them being confused for stock. And they were in the path of a fire exit route so could be a health and safety risk. Drug alerts were received electronically from the head office. There was an electronic audit trail to show who dealt with the alert, when and the action taken.

## 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 have processes to ensure equipment is properly maintained.

### 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, except one of the fridge doors had a failed seal. This meant the alarm of the fridge would alert staff until the door was closed correctly. This issue had been reported to the head office.

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. But the sink which was used to wash measures appeared messy, and the methadone designated measure had remnants from its last use.

Computers were password protected and screens were positioned so that they were not 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. |