General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Albert Wilde Ltd, West View Health Village, FLEETWOOD, Lancashire, FY7 8GU

Pharmacy reference: 1090930

Type of pharmacy: Community

Date of inspection: 30/01/2020

Pharmacy context

This is a community pharmacy located inside a medical centre. It is situated in a residential area of Fleetwood, on the Wyre coastline. The pharmacy dispenses NHS prescriptions, private prescriptions and sells over-the-counter medicines. It also provides a range of services including seasonal flu vaccinations and emergency hormonal contraception.

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 team follows written procedures, and this helps to maintain the safety and effectiveness of the pharmacy's services. The pharmacy 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 record things that go wrong and discuss them to help identify learning and reduce the chances of similar mistakes happening again.

Inspector's evidence

There was a current set of standard operating procedures (SOPs) which were issued in June 2019. But numerous members of the pharmacy team had yet to sign the updated SOPs. So it was not clear whether staff fully understood what was expected of them.

Dispensing errors were recorded electronically. A recent error which had occurred involved the incorrect supply of propranolol 10mg tablets instead of propranolol 40mg tablets. The pharmacist had investigated the error and shared his findings with members of the pharmacy team. Near miss incidents were also recorded electronically. The electronic records produced analytical graphs about common trends which had occurred during a particular month. The pharmacist explained that he would discuss the review with members of the pharmacy team each month. He would also highlight mistakes to staff at the point of accuracy check and ask them to rectify their own errors. Examples of action which had been taken were provided by the pharmacy team. For example, members of the team would check the correct address label was in the basket to help prevent hand out errors. Numerous posters about 'look alike, sound alike' medicines were on display in the pharmacy.

Roles and responsibilities of the pharmacy team were documented in the SOPs. A counter assistant was able to explain what her responsibilities were and was clear about the tasks which could or could not be conducted during the absence of a pharmacist. Staff wore standard uniforms and had badges identifying their names and roles. The responsible pharmacist (RP) had their notice displayed prominently. The pharmacy had a complaints procedure which was explained in the practice leaflet. Any complaints were recorded to be followed up by the pharmacist or head office. A current certificate of professional indemnity insurance was seen.

Records for the RP, private prescriptions, emergency supplies and unlicensed specials appeared to be in order. Controlled drugs (CDs) registers were maintained with running balances recorded and generally checked each month. Two random balances were checked. One was found to be accurate whilst a second had a deficit of 84 capsules. The pharmacist had identified the reason for the discrepancy and updated the records. Patient returned CDs were recorded in a separate register.

An information governance (IG) policy was available. The pharmacy team completed IG training and each member had signed a confidentiality agreement. When questioned, a dispenser was able to describe how confidential waste was segregated to be removed by an authorised waste carrier. A leaflet provided information about how people's data was handled and stored by the pharmacy.

Safeguarding procedures were included in the SOPs. Members of the pharmacy team had completed in-house safeguarding training and pharmacy professionals had completed level 2 safeguarding training.

Contact details for the local safeguarding board were on display in the dispensary. A trainee pharmacy technician said she would initially report any concerns to the pharmacist on duty.

Principle 2 - Staffing ✔ Standards met

Summary findings

There are enough staff to manage the pharmacy's workload and they are appropriately trained for the jobs they do. Members of the pharmacy team complete some additional training to help them keep their knowledge up to date.

Inspector's evidence

The pharmacy team included a pharmacist – who was also the superintendent (SI), a pharmacy technician – who was trained to accuracy check (ACT), three trainee pharmacy technicians, two dispensers, four medicine counter assistants (MCA) and three drivers. Members of the pharmacy team had completed the necessary training for their roles. The majority of staff worked full time, and usually there was a pharmacist, an ACT, five dispensary staff and two counter staff. A second pharmacist was present on a Wednesday, Thursday and Friday. The volume of work appeared to be managed. Staffing levels were maintained by a staggered holiday system and relief staff from nearby branches. A locum pharmacist and the SI were present during the inspection.

Members of the pharmacy team had completed some additional training, for example they had recently completed a training topic about Children’s oral health. But further training was not provided in a structured or consistent manner. So learning needs may not always be fully addressed.

A dispenser gave examples of how she would sell a pharmacy only medicine using the WWHAM questioning technique, refuse sales of medicines that were liable to abuse that she felt were inappropriate and refer people to the pharmacist if needed. The locum pharmacist said he felt able to exercise his professional judgment and this was respected by the pharmacy team and the head office. The trainee pharmacy technician said she received a good level of support and she felt able to ask for further help if she needed it. Appraisals were provided to members of the pharmacy team each year. A dispenser said she thought the appraisal process was a good chance to have a private conversation about her work and she felt able to speak about any of her own concerns. Staff were aware of the whistleblowing policy and said that they would be comfortable reporting any concerns to the head office or SI. The locum pharmacist said he was not set any targets for professional services.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are suitable for the services provided. A consultation room is available to enable private conversations.

Inspector's evidence

The pharmacy was clean and tidy, and appeared adequately maintained. The size of the dispensary was sufficient for the workload and access to it was restricted by the position of the counter. Part of the counter area was screened to help maintain privacy of conversations. The temperature was controlled by the use of air conditioning units. Lighting was sufficient. The staff had access to a kitchenette area and WC facilities.

A consultation room was available with access restricted by use of a lock. The space was clutter free with a computer, desk, seating, adequate lighting, and a wash basin. The patient entrance to the consultation room was clearly signposted and indicated if the room was engaged or available.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's services are easy to access. And it manages and provides them safely. It gets its medicines from recognised sources, stores them appropriately and carries out regular checks to help make sure that they are in good condition. But members of the pharmacy team do not always know when they are handing out higher-risk medicines. So they might not always be able to check that the medicines are still suitable, or give people advice about taking them.

Inspector's evidence

Access to the pharmacy was level via an entrance to the health centre and was suitable for wheelchair users. There was also wheelchair access to the consultation room. Pharmacy practice 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. If the pharmacy did not provide a particular service staff were able to refer patients elsewhere using a signposting folder. The pharmacy opening hours were displayed and a range of leaflets provided information about various healthcare topics.

The pharmacy had a delivery service. Deliveries were segregated after their accuracy check and logged onto an electronic delivery management system. An electronic device 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 letterbox indicating the pharmacy had attempted a delivery.

The pharmacy team used dispensing baskets to separate individual patients' prescriptions to avoid items being mixed up. The baskets were colour coded to help prioritise dispensing. Members of the team initialled dispensed by and checked by boxes on dispensing labels to provide an audit trail. The ACT said she would complete the final accuracy check of medicines if the prescription met a set criteria. For example, she could not check any new medicines which had been prescribed to patients. But there was no audit trail to show a clinical check had been completed or by whom. So in the event of a concern or query it may not be possible to identify which pharmacist carried out the check. And there is a risk that medicines could be supplied without clinical checks being made. Owing slips were used to provide an audit trail if the full quantity could not be immediately supplied. Dispensed medicines awaiting collection were kept on a shelf using a numerical retrieval system. Prescription forms were retained, 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.

Schedule 3 CDs were highlighted so that staff could check prescription validity at the time of supply. However; schedule 4 CDs were not. So there was a risk that these medicines could be supplied after the prescription had expired. High-risk medicines (such as warfarin, lithium and methotrexate) were not routinely highlighted. So the pharmacy team were not always aware when they were being handed out in order to check that the supply was suitable for the patient. The staff were aware of the risks associated with the use of valproate during pregnancy. Educational material was available to hand out when the medicines were supplied. The pharmacist said he would speak to any patients who were at risk to make sure they were aware of the pregnancy prevention programme, which would be recorded on their PMR.

The pharmacy offered a flu vaccination service using a patient group direction (PGD). Suitable equipment was available to provide the service, and the pharmacist said he had the necessary training to provide vaccinations. Records of successful vaccinations were kept, and the patient's GP surgery were informed.

Prescriptions for dressings and ostomy supplies were sent to be dispensed by an external appliance contractor. The pharmacy team said that they did not obtain consent from the patient for the prescription to be dispensed by another contractor. So people may not always have been aware that their personal information was being shared. Medicines were obtained from licensed wholesalers, and any unlicensed medicines were sourced from a specials manufacturer. The pharmacy was not yet meeting the safety features of the Falsified Medicine Directive (FMD), which is now a legal requirement. Equipment was installed but the pharmacy team had yet to commence routine checks of medicines. Expiry date of dispensary stock was checked on a 3-month basis. A date checking matrix was signed by staff as a record of what had been checked, and shelving was cleaned as part of the process. Short dated stock was highlighted using a sticker. Liquid medication had the date of opening written on.

Controlled drugs were stored appropriately in the CD cabinet, with clear segregation between current stock, patient returns and out of date stock. CD denaturing kits were available for use. There were clean medicines fridges, each with a thermometer. The minimum and maximum temperatures were being recorded daily and records showed they had been in range for the last 3 months. Patient returned medication was disposed of in designated bins located away from the dispensary. Drug alerts were received on an electronic system from the MHRA. Details of the action taken, by whom and when were electronically recorded.

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 maintain the equipment so that it is safe to use.

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. According to the stickers attached, electrical equipment had last been PAT tested in May 2015. 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. Equipment was kept clean.

A dispensing robot was used to assist the dispensing function and serviced twice a year. It contained an active monitoring system, which if a fault is detected will prompt a service engineer to contact or visit the pharmacy. Computers were password protected and screens were positioned so that they weren't 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. The consultation room was used appropriately; patients were offered its use when requesting advice or when counselling was required.

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.