General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: APA Ltd, 8 Alder Drive, Hoghton, PRESTON, Lancashire, PR5 0AD

Pharmacy reference: 1091671

Type of pharmacy: Community

Date of inspection: 30/04/2019

Pharmacy context

This is a community pharmacy which also contained a post-office counter. It is situated in the village of Gregson Lane, south east of Preston. The pharmacy dispenses NHS prescriptions, private prescriptions and sells over the counter medicines. It also provides a minor ailment service. A number of people receive their medicines inside multi-compartment compliance aids.

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 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 not all met	5.2	Standard not met	The medicines fridge is not consistently maintaining temperatures within the required range between 2C and 8C. This means the pharmacy cannot provide assurance that the medicines are being stored appropriately.

Principle 1 - Governance ✔ Standards met

Summary findings

The pharmacy team follows written procedures to help make sure the pharmacy provides services safely and effectively. But they do not record everything that goes wrong, and they do not always try to identify the things that may have caused the mistakes. So they may not always be doing everything they can to improve. People who work in the pharmacy are given training about the safe handling and storage of data. This helps to make sure that they know how to keep private information safe.

Inspector's evidence

There was a current set of Standard Operating Procedures (SOPs) which were last issued in July 2017 and their stated date of review was July 2019. The majority of the pharmacy team had signed to say they had read and accepted the SOPs. The counter assistant had not signed the SOPs so it is not clear whether they had read the latest version and understood them.

The pharmacist said she was not aware of any errors which had reached the patient. The pharmacy team were able to describe the process they would take in the event of an error including making a formal record and reviewing it to find any learning.

A paper log was available to record near miss errors. But there were few errors recorded and there was no formal review of these. The pharmacist said she would usually discuss an error with the staff present. A recent trend of picking errors involved selecting the incorrect inhaler. The pharmacist said she had spoken to the pharmacy team and discussed the different formulations and brands to help to reduce the picking errors.

There was a space to indicate the roles and responsibilities of the pharmacy team as part of individual SOPs, but these had not been completed. So members of the pharmacy team may not always be aware about their accountability within the pharmacy's processes. The MCA was able to describe what their responsibilities were and was also 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. Staff did not have badges identifying their name and role which means people may not know which member of the pharmacy team they are speaking to.

The pharmacy had a complaints procedure, but it was not on display. This means people may not know how to raise a complaint or provide feedback. Complaints were recorded to be followed up. Unresolved complaints could be escalated to the head office. A current certificate of professional indemnity insurance was on display in the pharmacy.

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. Patient returned CDs were recorded in a separate register.

An information governance (IG) policy was available. The pharmacy team received IG training and had signed confidentiality agreements. When questioned, the trainee dispenser was able to correctly explain how she would destroy confidential information using an on-site shredder. The company's privacy notice was displayed and described how patient data was handled.

Safeguarding procedures were included in the SOPs which were used by the pharmacy team as a form of training. The pharmacist said she had completed the CPPE safeguarding training. Contact details of the local safeguarding board were on display in the pharmacy. The trainee dispenser 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 properly trained for the jobs they do. Members of the pharmacy team participate in some ongoing training to help them keep their knowledge up to date. But there are no records or structure for this, so their learning needs may not always be fully met.

Inspector's evidence

The pharmacy team included a pharmacist manager, a pre-registration pharmacist (pre-reg), two trainee dispensers and a medicine counter assistant (MCA). The pharmacy team were adequately trained or in accredited training programmes. The post office was covered by the pharmacy team, and there were no non-pharmacy trained staffed involved in its operation. The normal staffing level was a pharmacist, pre-reg, and two other staff – one of whom would also cover the post office counter.

The volume of work appeared to be managed. Staffing levels were maintained by part-time staff and a staggered holiday system. Relief staff could be requested from the head office, but the pharmacist said she had not yet needed to request extra staff. During busy periods of the year, an extra member of staff was brought in to assist with the post-office function.

The pharmacy team said they would complete training when they have opportunity during the week and it is usually occurred more often than monthly. This was usually completed as a team alongside the pharmacist using a variety of material such as trade magazines or modules the pharmacist felt were appropriate. But this was not recorded.

The MCA gave an example of how she would sell a Pharmacy Only medicine using the WWHAM questioning technique, refuse co-codamol sales she felt were inappropriate and refer to the pharmacist if needed. The pharmacist said she felt able to exercise her professional judgment and she believed this was respected by the pharmacy team and the company.

The trainee dispenser said she was currently completing her dispensing course and she felt she received a good level of support from the pharmacy team. She felt able to ask them for help if she had any questions. There was no formal appraisal programme which would help to identify individual learning needs. The dispenser said she would feel comfortable raising any concerns she had with the pharmacist.

The staff held informal team meetings to discuss current issues, e.g. the workload, errors and complaints. There were no records kept of this, so staff who are not present may not be kept up to date with important information. A whistle blowing policy was in place and staff said that they would be comfortable to escalate any concerns to the head office. There were no targets set for the provision of services.

Principle 3 - Premises ✔ Standards met

Summary findings

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

Inspector's evidence

The pharmacy was clean and tidy and adequately maintained. The size of the dispensary was sufficient for the workload. A sink and washing facilities were available within the dispensary. Customers were not able to view any patient sensitive information due to the position of the dispensary and access was restricted by the position of the counter.

The temperature was controlled in the pharmacy by the use of electric heaters and fans. Lighting was sufficient. The staff had access to a kettle, microwave and WC facilities. A consultation room was available. A chaperone policy was on display.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's services are accessible to most people. And they are suitably managed to help make sure that they are provided safely. The pharmacy team checks the stock medicines to help ensure they remain in good condition. But they do this in a disorganised way which means some medicines are present that have gone out of date.

Inspector's evidence

Access to the pharmacy was level via a single door and was suitable for wheelchair users. The consultation room was wheelchair friendly and the PMR system was capable of producing large print font.

There was no practice leaflet or information on display the services offered by the pharmacy. So people may not always be aware about what services are available to them. The pharmacy opening hours were displayed at the entrance of the pharmacy and a range of leaflets provided information about various healthcare topics.

There were local restrictions in the area which prevented the pharmacy from ordering prescriptions on behalf of the patient. The pharmacy had a delivery service. Deliveries were segregated after their accuracy check and a delivery sheet was used to obtain patient signatures on receipt of the medication. Unsuccessful deliveries would be returned to the pharmacy and a card posted through the letterbox indicating the pharmacy had attempted a delivery.

Dispensed by and checked by boxes were initialled on medication labels to provide an audit trail. Dispensing baskets were used for segregating individual patient prescriptions to avoid items being mixed up and the baskets were colour coded to help prioritise dispensing. Owing slips were in use to provide an audit trail if the full quantity could not be immediately supplied.

Dispensed medicines awaiting collection were segregated away from the dispensing area on a collection shelf using an alphabetical retrieval system. Prescription forms were retained and stickers were used to 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.

The pharmacy team did not specifically show fridge items to the patient upon handout. This would allow the patient to confirm that they were correctly prescribed and dispensed. Schedule 3 CDs stored on collection shelves were highlighted to indicate their presence so that staff could check prescription validity at the time of supply, however; schedule 4 CDs were not. So there is a risk that these medicines could be supplied after the prescription had expired.

INR results were normally checked for patients prescribed Warfarin. But prescriptions for warfarin and other high-risk medicines (e.g. lithium and methotrexate) were not routinely highlighted. So the pharmacy team may not be aware when they are being handed out in order to check that the supply is

suitable for the patient.

The staff were aware of the risks associated with the use of Valproate during pregnancy. Product literature was available to hand out to patients, but the pharmacy team said there were currently no female patients who met the criteria.

An individual record sheet was kept for all MDS patients, containing details of current medication. Any medicine changes were confirmed with the GP surgery before the record sheet was amended. Hospital discharge information was sought, and previous records were retained for future reference. Disposable equipment was used to provide the service, and the MDS packs were labelled with descriptions so that individual medicines could be identified. Patient information leaflets (PILs) were routinely supplied. The dispensing audit trail was not always completed to identify everyone involved in the process. This meant, in the event of an error or concern, it may not always be possible to identify who was responsible.

The pharmacy was not yet compliant with the falsified medicine directive (FMD), which is now a legal requirement. New equipment had been installed but the safety checks were not yet being conducted.

Staff said dispensary stock was date checked on a four-month rotating cycle. There were no records kept to show when date checking had been completed. The pharmacy team said they had recently completed date checking and marked short dated stock with a highlighter pen. A spot check of the dispensary stock found the majority of the dispensary to be in date. But it appeared that liquid medicines had been overlooked as four bottles for a variety of medicines were found to have expired.

Controlled drugs were stored appropriately in the CD cabinet, with some segregation between current stock, patient returns and out of date stock. CD denaturing kits were available for use. Patient returned medication was segregated from current stock in the toilet. But these had not been processed and placed into DOOP bins. This may pose a health and safety risk to members of the pharmacy team.

Drug alerts were received electronically on the "PharmOutcomes" system, but no records were kept to show the action taken. So the pharmacy team cannot demonstrate that alerts have been dealt with appropriately.

Principle 5 - Equipment and facilities **Standards not all met**

Summary findings

The pharmacy team has access to the equipment they need for the services they provide. But the temperature inside the fridge regularly went outside of the required range between 2C and 8C. So it may not be functioning correctly to maintain a suitable temperature for medicines storage.

Inspector's evidence

The staff had access to the internet for general information. This included access to medicine information on the BNF, BNFc and drug tariff resources. There was a clean medicines fridge with a minimum and maximum thermometer. The minimum and maximum temperature was being recorded daily and records indicated it had been in range for the last 3 months. However; the temperature was checked on 3 occasions during the inspection and found to be outside the required range. Initially it was found to have a current temperature of 2.3C, with the minimum recorded at -5.9C. On the next two occasions the current temperature was at -0.1C and -0.8C.

There was a selection of liquid measures with British Standard and Crown marks. The pharmacy also had counting triangles for counting loose tablets including a designated tablet triangle for cytotoxic medication

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 in the services provided by the pharmacy; 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.