General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Curo Pharmacy, St. Georges Surgery, 62 Haslingden Road, BLACKBURN, Lancashire, BB2 3HS

Pharmacy reference: 1091896

Type of pharmacy: Community

Date of inspection: 03/08/2022

Pharmacy context

The pharmacy is next to a health centre on the outskirts of Blackburn. It is open extended hours, seven days a week. The pharmacy mainly dispenses NHS prescriptions and sells over-the-counter medicines. It dispenses some medicines in multi-compartment compliance packs, to help people take their medicines correctly. And it delivers some people's medicines to their home. The pharmacy provides some NHS services such as substance misuse services, the Community Pharmacist Consultation Service (CPCS) and the Hypertension Case-Finding Service to support people in the community.

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	1.2	Good practice	The pharmacy is good at learning from dispensing mistakes. It regularly reviews its records and it is good at sharing the learning and trends with the team, including regular locums. And the pharmacy makes suitable changes following mistakes, to improve the safety of its services.
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 suitably identifies and manages the risks with its services. Team members are good at learning from any mistakes they make. And they make changes to the way they work to reduce the risk of similar mistakes. Team members mostly make the records they must by law, and they keep people's private information secure. They listen to people's views and they make changes to help people receive better care. Team members know their role in helping protect vulnerable people.

Inspector's evidence

The pharmacy team continued to manage the risks associated with COVID-19 by wearing masks and using hand sanitiser. The pharmacy superintendent (SI) assessed risks of different ways of working without formally recording them. For example he recognised some existing risks, with dispensing multi-compartment compliance packs. The pharmacy had a set of up-to-date standard operating procedures (SOPs). The SI had authorised them and made changes to the templates to fit in with working practices in the pharmacy. The SOPs included those for controlled drug (CD) management, Responsible Pharmacist (RP) regulations and dispensing. The pharmacy team had read previous SOPs but had not yet had the opportunity to read the updated SOPs, even though these latest ones had been reviewed in August 2021. Team members demonstrated a clear understanding of their roles and they were seen working within the scope of their role, requesting support from the pharmacist when needed. The correct RP notice was displayed, and it was changed when there was a changeover of RP during the inspection, so it was clear to people who was on duty.

The pharmacy team regularly discussed and recorded errors that were identified during the dispensing process, known as near miss errors. The cause and potential contributory factors to these errors was captured and this information fed into the recorded actions taken. The pharmacy held the information electronically and the SI analysed the data to produce a monthly report. This included bar graphs that helped the team see information about most common errors at a glance. The report was shared with team members and regular locum pharmacists by email and on the team's instant messaging application. The SI also shared any dispensing errors, these were errors that had not been identified before the person received the medicine. A thorough investigation was carried out following any such errors, and team members were able to reflect and learn from them. Team members had a good knowledge of the risks of selection errors with medicines with similar names and similar packaging. They explained how making changes to the shelves where they stored the fast-moving medicines had meant medicines such as amitriptyline and amlodipine were no longer stored together. And as they didn't store all strengths of medicines on these shelves the team reported fewer errors involving selecting the wrong strength of a medicine. The SI and team members clearly explained their roles in managing any complaints from people. They reported few formal complaints, and a dispenser gave some examples of changes the pharmacy had made for individual people after they had raised concerns.

The pharmacy had up-to-date professional indemnity insurance. A sample of the electronic RP register met legal requirements and CD records mostly met requirements. The pharmacy regularly checked the physical quantity of CDs against the register to identify any issues such as missed entries. The physical quantity of one CD checked, matched the register entry. The pharmacy kept complete records for the unlicensed specials medicines it supplied. The electronic private prescription records were mostly

correct, but the prescriber in three of the records checked had not been completed correctly.

Team members understood the importance of keeping people's private information secure, this included the delivery driver who showed how he kept people's names and addresses private on his delivery sheet. Team members completed a confidentiality agreement on commencing employment and confidentiality training was included in an annual refresher training. They separated confidential waste for shredding offsite. The RP and SI had completed Level 2 safeguarding training within the last two years. Team members hadn't received any recent formal training, but a dispenser was clear how to raise any concerns with the RP or SI.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy's suitably qualified and skilled team members manage the workload well. They work in an open and honest way to improve services and make them safer. And they complete some ongoing learning to keep their knowledge up to date. They feel comfortable raising concerns and discussing ideas to improve services.

Inspector's evidence

There were two different RPs during the inspection, both regular locum pharmacists. They completed a brief handover and completed the change in the RP notice and log-in efficiently. Often two or three pharmacists covered the extended opening hours in a day, and the SI worked at the pharmacy regularly. He was present for part of the inspection. The RP on occasions worked alone and services could be provided though a hatch so that the premises could be secured. The SI had assessed and managed the risks of this well. He organised the staff rota according to the workload, and this was seen to be effective during the inspection as more team members started work as the pharmacy got busier. There was a full-time and a part-time dispenser working with a long-term locum dispenser at the busiest times. The pharmacy had experienced some workforce challenges with the pharmacist manager leaving and two team members on maternity. But a new pharmacist manager was due to start, and the SI had recently employed a new part-time team member, who was registered on a joint medicines counter assistant and dispenser course. The team was seen to be managing the workload in an efficient way. The pharmacy had two experienced delivery drivers and cover for holidays. The drivers were seen to be sorting their workload of deliveries in an organised manner.

The SI completed some ongoing training with the team, and this included training included for completion of the NHS Pharmacy Quality Scheme (PQS). Team members didn’t have a formal individual training programme and had not received the opportunity of a recent appraisal. Team members felt comfortable raising concerns with the SI, who they felt was supportive. They described how ideas they discussed together had been implemented, such as changes to the arrangement of the fast-moving medicines shelves. They felt this meant they worked more efficiently and with fewer errors. The SI and team members spoke about their near miss and dispensing errors in an open and honest way, with a focus on learning and making the processes safer. The pharmacist and team members were seen making professional decisions within their roles and giving people suitable advice. They discussed demand for over-the-counter medicines subject to misuse and how they felt confident and supported in refusing supplies to people.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are suitable for the services provided. And they are clean, hygienic and well maintained. The team uses a good-sized room to talk to people and to provide services in private.

Inspector's evidence

The pharmacy premises were on the same site as the health centre and were well maintained, clean and hygienic. They were of a suitable size for the services provided, with a retail area, dispensary, an office, a stock room and a staff room. There was enough bench space for dispensing and enough shelving and continental drawers for storage of medicines. The pharmacy had hot and cold running water for professional use and as part of the staff handwashing facilities. It had air-conditioning to keep the temperature suitable, and the lighting was bright. The team kept the floors clear and the benches suitably uncluttered. The SI described the plans for a refit to improve the retail area, consultation room and pharmacy counter.

The large consultation room was well organised and provided a professional environment for services and private consultations. It had frosted glass on the windows to prevent people looking into the room from the retail area. The signage for the room was hidden by a healthcare stand. The pharmacy's website was not live.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides access to its services over extended hours to help support people's health. It manages and delivers it services safely, with team members following robust processes and making some good records. The pharmacy manages and stores its medicines properly and tidily.

Inspector's evidence

Access to the pharmacy was on a level with the pavement outside, which meant people with reduced mobility and using wheelchairs had access to the premises. There were chairs to sit on in the waiting area. The pharmacy was open extended hours seven days a week. It opened before the health centre next door and closed late into the night. During these times pharmacists provided advice and dispensing services through a hatch opening on to the walkway outside the pharmacy. The pharmacy provided the Community Pharmacist Consultation Service (CPCS), with good access to the service due to its opening hours. The SI reported that there was not a huge uptake for the service either from NHS111 or the GP surgeries. The pharmacy had a busy delivery service. The drivers worked well together to work out an efficient route and they kept a record of the deliveries. They obtained signatures from people on delivery and returned the record sheets to the pharmacy at the end of the shift along with any undelivered medicines.

The pharmacy focussed on delivering its NHS dispensing services. Team members used baskets when dispensing to keep people's medicines and prescriptions separate to reduce the risk of mistakes. They initialled the dispensed by and checked by boxes on dispensing labels to provide an audit trail. The use of stickers on the dispensing bags, highlighted to the team if a CD and fridge line had been dispensed. This helped reduce the risk of handout errors and provided opportunities for giving advice. Prescriptions were labelled, dispensed, and checked in separate areas and the workflow was organised. The pharmacy dispensed medicines into multi-compartment compliance packs for some people to help them take their medicines properly. It had a SOP for the service. The service was well organised and the workload for a particular week was well defined. Team members knew on which week people needed their prescriptions ordering, dispensing, and delivering. This information was recorded to create an audit trail in case of queries. Some people ordered their own prescriptions and for others the team ordered. This was clearly recorded. Prescriptions were ordered up to two weeks in advance to make sure the team sorted out any queries and delivered people's packs when they needed them. The team reminded people who ordered their own prescriptions when it was time to order. The SI knew of the potential risks of ordering early and the pharmacy team understood the importance of recording and actioning any changes in people's medicines. A dispenser demonstrated how they attached discharge information to the person's PMR record and how they made changes to the records. Team members signed labels created to record the audit trail of who was responsible for each part of the dispensing process. They supplied patient information leaflets (PILs) once a month. The completed packs and medicines were stored in a separate room in large baskets. Some baskets were stored on top of the other so there was a small risk of medicines or packs getting mixed up. The pharmacy supplied some medicines on instalment prescriptions, and it made these up in advance to help with the workload. It stored them securely and kept different people's doses separate to reduce the risk of error. The team understood the importance of taking care when dispensing valproate, and the risks of taking it when a person was pregnant. They described how they dispensed it in the original manufacturer's packs and avoided putting the labels over the warnings on the box. The pharmacist was aware of the valproate

pregnancy prevention programme and the requirements for counselling and providing patient cards.

The pharmacy kept pharmacy (P) medicines in glass fronted cabinets in the retail area, with signage directing people to ask for assistance. It obtained medicines from recognised wholesalers. It kept its medicines and medical devices well organised and very tidy on shelves and in continental drawers. Different strengths were clearly separated, as were medicines that looked and sounded similar. The team completed regular checks of expiry dates and recorded these checks. Medicines with reduced expiry dates were seen to be clearly annotated. No out-of-date medicines were found on the shelves. The pharmacy recorded the maximum and minimum temperatures in the medical fridge daily and it was within the required range during the inspection. Medicinal waste bins containing out-of-date and patient-returned medicines were neatly stored. The team actioned patient safety and medicine recalls following the receipt of emails from the Medicines and Healthcare products Regulatory Agency (MHRA). The team printed off the alert and kept a record of the actions taken.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide its services. And it uses its equipment and facilities to suitably protect people's private information.

Inspector's evidence

The pharmacy had medical reference resources and use of the internet for up-to-date information. It had password-protected computers and it restricted access to people's records by the use of NHS Smart cards. The computer screens were positioned to prevent unauthorised access to any sensitive information. The team used cordless telephones for private conversations with people. Completed prescriptions were stored away from public view and the team held private information in the areas of the pharmacy with restricted public access.

The pharmacy team had equipment for dispensing including a range of suitable glass measures, which were labelled to avoid cross-contamination. The team used disposable consumables to dispense medicines in compliance packs and used large baskets to keep people's medicines and compliance packs separate. The medical fridge appeared in good working order and was of a suitable size. The pharmacy had a number of blood pressure monitors, including one that had not been maintained for several years. This one was reportedly not in use. The SI provided the NHS Hypertension Case-Finding service and had purchased an ambulatory blood pressure monitor, which was on the list of monitors validated for use by the British and Irish Hypertension Society.

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.