General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Rufford Pharmacy, 124 Liverpool Road, Rufford, ORMSKIRK, Lancashire, L40 1SB

Pharmacy reference: 1092406

Type of pharmacy: Community

Date of inspection: 04/07/2019

Pharmacy context

This is a community pharmacy in a rural location. It is situated on a main road between Liverpool and Preston in the village of Rufford, west Lancashire. The pharmacy dispenses NHS prescriptions, private prescriptions, sells over-the-counter medicines, and provides seasonal flu vaccinations. A number of people receive their medicines in 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 not all met	2.2	Standard not met	A number of people are not appropriately trained for the jobs they do, so they may not always work safely and effectively.
3. Premises	Standards met	N/A	N/A	N/A
4. Services, including medicines management	Standards not all met	4.2	Standard not met	The pharmacy's delivery service was not managed in a way which reflected the SOPs. And the pharmacy team could not demonstrate it was provided safely and effectively.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance ✔ Standards met

Summary findings

The pharmacy has written instructions to help make sure that members of staff work safely and effectively. But the instructions have not been reviewed for several years so some may be out of date. Members of the pharmacy team do not always make records of things that go wrong. So they may miss opportunities to learn from them and prevent the same mistakes happening again. The pharmacy keeps the records it needs to by law. Members of the pharmacy team have not read the latest data protection policy. So they may not always know how to protect people's information.

Inspector's evidence

There was a set of Standard Operating Procedures (SOPs) which had not been reviewed since February 2015. So they may not always reflect current practice. There were training sheets attached to the SOPs that staff were supposed to sign to confirm they had read and understood them. Staff said they had read the SOPs, but a number of the training sheets had not been signed by all members of the pharmacy team. So it was not clear whether staff fully understood what was expected of them.

Dispensing errors were recorded on a standardised form and submitted to the superintendent (SI). The last error involved the incorrect supply of Flecenaide 100mg tablets instead of Flubiprofen 100mg tablets. The pharmacist investigated the error, made the staff aware and moved these medicines away from each other in the dispensary. A paper log was available to record near miss errors. The last record was in January 2019. The pharmacist admitted some near miss errors had not been recorded. He said he would usually inform staff about a near miss when it occurred but could not provide an example of any learning points identified from near misses.

Roles and responsibilities of the pharmacy team were documented on a matrix. A dispenser was able to describe what her 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. The pharmacy had a complaints procedure. This was on display in the retail area and advised people to discuss their concerns with members of the pharmacy team. Complaints were recorded to be followed up by the pharmacist or superintendent. A current certificate of professional indemnity insurance was on display in the pharmacy.

Controlled Drugs (CDs) registers were maintained with running balances recorded. The balance of Zomorph 10mg capsules, Oxycodone 10mg MR tablets and Fentanyl 12mcg patches were checked and found to be accurate. Patient returned CDs were recorded in a separate register. Records for the RP, private prescriptions, emergency supplies and unlicensed specials appeared to be in order.

An information governance (IG) policy was available. But it was out of date, and staff had not read the new policy which reflected GDPR requirements. So they may not fully understand their responsibilities to comply with GDPR requirements. The dispenser said she had signed a confidentiality agreement. When questioned, the technician was able to describe how confidential information was destroyed using an on-site shredder. The pharmacy's practice leaflet described how patient data was handled. There was no privacy notice on display, which is a legal requirement.

Safeguarding procedures were available, which the pharmacy team said they had read. The pharmacist said he had completed level 2 safeguarding training. Contact details of the local safeguarding board

were available. The technician said she would initially report any concerns to the pharmacist on duty.

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

Summary findings

There are enough staff to manage the workload. But a number of people are not appropriately trained for the jobs they do, so they may not always work safely and effectively.

Inspector's evidence

The pharmacy team included a pharmacist manager, a pharmacy technician and a driver. There were also two other staff who had been working for over three months but had yet to be enrolled onto an accredited training programme. The pharmacist said their responsibilities included the assembly of medicines and management of stock. So two members of the pharmacy team have not completed the necessary training to meet GPhC minimum training requirements. A school work experience student was on current placement for a week. He was seen to serve customers and put stock away. He said he did not sell any medicines without the supervision of another member of staff.

The normal staffing level was a pharmacist and two other staff. The volume of work appeared to be managed. Staffing levels were maintained by part-time staff and a staggered holiday system. Relief staff could also be requested from another branch.

Members of the pharmacy team said they would read training magazines received through the post to help keep their knowledge up to date. But this activity was not recorded or completed in a structured way. So learning needs may not always be addressed. One of the pharmacy team members who had yet to complete accredited training, said she would obtain as much detail about a request for a Pharmacy Only medicine and refer all sales to the pharmacist.

The pharmacist said he felt able to exercise his professional judgment and this was respected by the SI. The technician said she received a good level of support from the pharmacist and felt able to ask for further help. She said she would receive feedback about her work and felt able to raise any concerns she had. Members of staff did not have appraisals, so their specific learning and development needs may not always be identified.

Staff were aware of the whistle blowing policy and said that they would be comfortable reporting any concerns to the manager or SI. A target for MURs was set but the pharmacist said he did not feel under pressure to achieve it.

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 adequately maintained, but it appeared cluttered with boxes on the floor in the dispensary. This increases the risk of a tripping hazard. The size of the dispensary was sufficient for the workload. A sink was 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, separate staff fridge, and WC facilities.A consultation room was available. The space was clutter free with a desk, seating and adequate lighting. The patient entrance to the consultation room was clearly signposted.

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

Summary findings

The pharmacy's services are easy to access. But they do not always have effective controls in place to make sure medicines are supplied appropriately. And they do not always provide people with all of the information they might need to take their medicines safely. The pharmacy gets its medicines from appropriate sources, stores them appropriately and carries out some checks to help make sure that they are in good condition.

Inspector's evidence

Access to the pharmacy was level via a single door and was suitable for wheelchair users. There was wheelchair access to the consultation room. Pharmacy practice leaflets gave information about the services offered. 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 using signposting information. 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 people. The pharmacy had a delivery service. But it was not provided in accordance with the company's SOPs. So the pharmacy cannot demonstrate it is safe and effective.

Dispensed by and checked by boxes were initialled on dispensing labels to provide an audit trail. Dispensing baskets were used for segregating individual patients' prescriptions to avoid items being mixed up and the baskets were colour coded to help prioritise dispensing. Dispensed medicines awaiting collection were segregated away from the dispensing area on a collection shelf using an alphabetical retrieval system. Prescription forms were not always retained; the pharmacist said he would the patient's PMR if needed. 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 and 4 CDs were not routinely highlighted. So there is a risk some medicines may be supplied past their expiry date. And members of the pharmacy team may fail to mark schedule 3 prescriptions with the date (which is a legal requirement to be completed at the time of supply). High-risk medicines (such as warfarin, 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 pharmacist was aware of the risks associated with the use of Valproate during pregnancy. He said he did not think there were any patients that met the risk criteria. But little had been done to help identify relevant patients or check whether supplies were appropriate. So there is a risk that insufficient checks are completed before the supply is made. Educational materials were available to hand out when the medicines were supplied.

Some medicines were dispensed in MDS compliance aids. A record sheet was kept for all MDS patients; containing details of current medication. Any medication changes were confirmed with the GP surgery before the record sheet was amended. Hospital discharge sheets were sought. Disposable equipment was used to provide the service, and the MDS packs were labelled with a dispensing check audit trail. But descriptions of medicines and patient information leaflets (PILs) were not routinely provided. So people may not be able to identify individual medicines they are taking and may not have all the

information they might need to take the medicines safely.

The pharmacy offered blistered medication to care homes. A re-order sheet was provided to the pharmacy and it contained details about the medicines required, medicine changes and any handover notes for the pharmacy. When prescriptions were received from the GP surgery they would be compared to the re-order sheet to confirm all medicines were received back. Any queries were written onto a query sheet and chased up with the GP surgery. A copy of the query sheet was provided to the care home. Some of the medicines were dispensed into disposable compliance aids and a dispensing and checking signature was written onto the seal.

Prescriptions for dressings and ostomy supplies were sent to be dispensed by an external appliance contractor. The pharmacist said that consent was not obtained from the patient for the prescription to be dispensed by another contractor. So people may not always be aware that their personal information is being shared. Medicines were obtained from licensed wholesalers, with unlicensed medicines sourced from a special's 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 safety checks of medicines.

There was a record of expired stock and short dated stock from the previous date check. Stickers were attached to medicines which were short-dated to alert staff. But there was no formal programme for how often medicines were date checked. So there is a risk that some medicines may be overlooked. A spot check of some medicines did not find any out of date stock. 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 DOOP bins located away from the dispensary. Drug alerts were received electronically by email. The pharmacist said he would read these and action those which were relevant. But records about this was not kept. So the pharmacy may not be able to demonstrate what they have done in receipt of a recall or alert.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy's team members have access to the equipment they need for the services they provide.

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, all electrical equipment had been PAT tested in January 2014. There was a selection of liquid measures with British Standard and Crown marks. The pharmacy also had counting triangles for counting loose tablets.

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.