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: 28/01/2020

Pharmacy context

This is a community pharmacy situated on a major road between Liverpool and Preston. It is located in the rural village of Rufford, in West Lancashire. The pharmacy dispenses NHS prescriptions, private prescriptions, sells over-the-counter medicines, and provides 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 met	N/A	N/A	N/A
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 is not provided in accordance with the SOPs. And the pharmacy team cannot demonstrate it is provided safely and effectively. Members of the pharmacy team do not always have enough information about medicines they are handing out. So they may not be able to make appropriate checks or give advice to people.
		4.3	Standard not met	Multi-compartment compliance aids are left unsealed for prolonged periods of time during dispensing. This means the medicines may not be kept in good condition and there may be more risk of things going wrong.
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 not be in line with current practice. The pharmacy keeps the records it needs to by law. But members of the 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. And they have not read the latest data protection policy. So they may not always know how they are expected to handle private information.

Inspector's evidence

There was a set of Standard Operating Procedures (SOPs). Some had been reviewed in February 2017, but a number of them had not been reviewed since February 2015. So they may not always reflect current practice. Members of the pharmacy team said they had signed training sheets to say they had read and understood the SOPs, but these could not be found.

Dispensing errors were recorded on a standardised form. The pharmacist explained that he would record and investigate when an error occurred. But he was not aware of any errors which had occurred recently. A paper log was available to record near miss incidents. The last record was made in October 2019. The pharmacist admitted some near miss errors had not been recorded. He said he would inform staff about a near miss when it occurred and ask them to correct it. Examples of action which had been taken in response to near miss errors were provided. Such as using baskets to segregate different strengths of levothyroxine and warfarin on dispensary shelves.

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. A notice in the retail area advised people they could discuss any concerns or feedback with the pharmacy team. Any complaints would be recorded to be followed up by the pharmacist or SI. A current certificate of professional indemnity insurance was available.

Controlled Drugs (CDs) registers were maintained with running balances recorded and usually checked each month. Two random balances were checked, and both 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 members of the pharmacy team may not fully understand their responsibilities to comply with GDPR requirements. A dispenser said she had signed a confidentiality agreement. When questioned, members of the pharmacy team were able to describe how confidential waste was segregated to be removed by a waste carrier. A privacy notice was on display and provided details about how people’s data was handled and stored.

Safeguarding procedures were available. Members of the pharmacy team had in-house training and pharmacy professionals had completed level 2 safeguarding training. Contact details of the local safeguarding board were available. A 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 workload. 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 manager, three dispensers – one of whom was in training, and a driver. The normal staffing level was a pharmacist with three assistants in the morning and two in the afternoon. 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 if necessary. 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 fully addressed.

A dispenser gave examples of how she would sell a pharmacy only medicine using the WWHAM questioning technique, refuse sales she felt were inappropriate and refer people to the pharmacist if needed. The pharmacist said he felt able to exercise his professional judgment and this was respected by the SI. A dispenser commenced her employment about 3 months ago. She said she felt a good level of support from the pharmacist and felt able to ask members of the pharmacy team for further help if needed. A dispenser said she would receive feedback from the pharmacist during her work and she felt able to speak about any of her own concerns to the pharmacist. Staff were aware of the whistle blowing policy and said that they would be comfortable reporting any concerns to the manager or SI. There were no targets set 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 adequately maintained. But it appeared cluttered and there were boxes on the floor in the dispensary that were a tripping hazard. The size of the dispensary was sufficient for the workload, and access to it was restricted by the position of the counter. A sink was available within the dispensary. Customers were not able to view any patient sensitive information due to the position of the dispensary. 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 cannot show that medicines are always stored appropriately, and there aren't always effective controls in place to make sure medicines are supplied appropriately. They do not always provide people with all of the information they might need to take their medicines safely.

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 and a range of leaflets provided information about various healthcare topics.

The pharmacy had a delivery service. But it was not provided in accordance with the SOPs. When deliveries were made to people, records were not kept about who the delivery was made to and when. Signatures were not obtained from recipients. So the pharmacy was not able to demonstrate that medicines had been appropriately delivered. A number of deliveries were posted through people's letterboxes or left at alternative locations. The pharmacist said the driver would not do this unless a verbal risk assessment had been completed. But SOPs did not mention this arrangement and there was no evidence the suitability of the arrangement was kept under review.

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 kept on a shelf using an alphabetical retrieval system. Prescription forms were not retained. So the pharmacy team may not have all of the information they need when medicines are handed out. 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.

The pharmacist said prescriptions for schedule 3 and 4 CDs were kept and that they were highlighted so staff could check prescription validity at the time of supply. But no examples of this were available. 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 team said they were not aware of any current patients who met the risk criteria.

Some medicines were dispensed in multi-compartment compliance aids. Before a person was started on a compliance aid the pharmacy would refer them to their GP to complete an assessment about their suitability. 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. 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. But compliance aids were normally assembled on a Thursday or Friday and usually left unsealed before they were accuracy checked by the pharmacist the following Wednesday.

The pharmacy dispensed medicines for a number of patients who were residents of 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 for the care home to chase up with the GP surgery. 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 patients did not give consent for their 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, 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 checks of medicines. The pharmacy team said they would check the expiry dates of stock from a section of the pharmacy each month. But this was not recorded. So it was unclear when stock had last been checked and there was a risk some sections could be overlooked. Stickers were attached to medicines which were short-dated to alert staff and liquid medication had the date of opening written on. A spot check of the dispensary stock did not find any expired medicines.

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 two clean medicines fridges, each with a thermometer. The minimum and maximum temperatures were being recorded each day for one of the fridges. But temperatures for the other fridge were not recorded. So the pharmacy could not demonstrate whether the temperature had remained appropriate. Patient returned medication was disposed of in DOOP bins located away from the dispensary. Drug alerts were received electronically by email from MHRA. The pharmacist said he would read these and action any that were relevant. But records about this was not kept. So the pharmacy was not able to show whether appropriate action had been 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 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, all electrical equipment had been PAT tested in January 2020. There was a selection of liquid measures with British Standard and Crown marks. The pharmacy also had counting triangles for counting loose tablets. Equipment was kept clean.

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.