General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Eccles Chemist, 67-69 Union Road, Oswaldtwistle, ACCRINGTON, Lancashire, BB5 3DD

Pharmacy reference: 1092671

Type of pharmacy: Community

Date of inspection: 14/05/2019

Pharmacy context

The pharmacy is on a high street in Oswaldtwistle. Pharmacy team members mainly dispense NHS prescriptions and sell a range of over-the-counter medicines. And, they offer services including medicines use reviews (MUR) and the NHS New Medicines Service (NMS). They provide a substance misuse service, including supervised consumption, and they supply medicines in multi-compartmental compliance packs to people in their own homes and a nursing home. Pharmacy team members provide blood pressure testing, weight loss advice, a stop smoking service and emergency contraception via NHS patient group direction (PGD).

Overall inspection outcome

✔ **Standards met**

Required Action: None

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 met	N/A	N/A	N/A

Principle 1 - Governance ✔ Standards met

Summary findings

The pharmacy has procedures to identify and manage risks. It keeps them up to date. The pharmacy has systems in place to manage complaints and people can give feedback about its services. The pharmacy maintains the pharmacy records it must by law. But, it does not regularly check that the records it keeps for some medicines match what is in stock. And, when discrepancies are found the team doesn't investigate properly. Pharmacy team members read and follow the procedures. And, they know how to keep people's private information secure. They understand how important their role is in keeping people's information safe. And they know what to do if there is a concern about the welfare of a child or vulnerable adult. But, they struggle to find key documents and evidence when their manager is absent. The team members record and discuss mistakes that happen. They use this information to learn and make changes to help prevent similar mistakes happening again. But they don't always discuss or record enough detail about why these mistakes happen. So, they may miss opportunities to improve.

Inspector's evidence

The pharmacy had a set of standard operating procedures (SOPs) in place. It had reviewed the procedures in 2018. And had scheduled the next review of the procedures for 2020. Pharmacy team members had read and signed the SOPs after the review in 2018. They had completed an online SOP quiz testing their knowledge of procedures. And there were records confirming they had successfully completed the quiz. The pharmacy defined the roles of the pharmacy team members in the SOPs. Tasks were also defined on a sheet displayed in the dispensary. Pharmacy team members explained this was because most of them were new and were still developing their roles within the team.

The pharmacist highlighted near miss errors made by the pharmacy team when dispensing. They did this by placing a pink alert card in the dispensing basket. And, handed the basket back to the dispenser to correct. Pharmacy team members recorded their own mistakes. The pharmacy team discussed the errors made each week. But, they did not discuss or record much detail about why a mistake had happened. They usually said rushing had caused the mistakes. And, they said their most common change after a mistake was to double check next time and be more careful. The pharmacist analysed the data collected about mistakes every month. But, there were no records of analysis available in the pharmacy because the pharmacist had taken the file home to review during her week off.

The pharmacy had separated medicines with similar names and packaging to help prevent mistakes when selecting medicines. And they had attached warning stickers to the edges of shelves in front of these medicines to alert staff to the risks. The pharmacy had a clear process for dealing with dispensing errors. It recorded incidents on a template incident report form, usually done by the pharmacist. But, the pharmacy team could not find the incident report file where reports were kept. So, the inspector could not assess the quality of dispensing error reporting and learning.

Pharmacy team members advised they would refer someone reporting a dispensing error to the pharmacist. The locum pharmacist advised he would assess the situation and the immediate risk to the patient. And, would make the necessary referral to make sure the patient was safe, for example referring to the GP or hospital. He would then seek advice from the superintendent's office about where to record an error.

The pharmacy had a procedure to deal with complaints handling and reporting. But, it did not clearly signpost people to the procedure. It collected feedback from people by using questionnaires. And, it displayed the feedback from the last set of questionnaires to be analysed. One feedback point was for pharmacy team members to provide more advice about leading a healthy lifestyle. A dispenser explained they had posters and leaflets available providing advice about various health topics. And, some staff were trained as healthy living champions. But, these measures were in place before the feedback had been received. And, nothing further had been done to raise people's awareness of the team's ability to provide advice and support about healthy living.

The pharmacy had up to date professional indemnity insurance in place. The pharmacy kept controlled drug (CD) registers complete and in order. It kept running balances in some registers, but not all. Several CD registers were found where a discrepancy had been found and the balance had either been adjusted without explanation or a sticky label had been attached with a quantity written on and no further running balances had been recorded. One example of this was the register for Oxycodone 15mg MR tablets. Another example was the register for Oxycodone 5mg capsules. The pharmacy team members present could not provide an explanation. They said the CD registers were checked by the pharmacist or the supervisor, neither of which were available during the inspection. The pharmacy kept and maintained a register of CDs returned by people for destruction. But, there were several CDs returned that had not been destroyed. And, some segregated as patients returned that had not been recorded. The pharmacy maintained a responsible pharmacist record electronically. And it was complete and up to date. The pharmacist displayed their responsible pharmacist notice to people. The pharmacy team monitored and recorded fridge temperatures daily. They kept private prescription records in a paper register, which was complete and in order. And, they recorded emergency supplies of medicines electronically. They recorded any unlicensed medicines supplied, which included the necessary information in the samples seen.

Pharmacy team members said they had been trained to protect privacy and confidentiality. But there were no records available to confirm when the training had been done. Pharmacy team members were clear about how important it was to protect confidentiality. But, they could not find any procedures relating to information governance.

When asked about safeguarding, a dispenser gave some examples of symptoms that would raise their concerns in both children and adults. They explained how they would refer to the pharmacist. The pharmacist said they would assess the concern. And would refer to local safeguarding teams or head office for advice. The pharmacy had contact details available for the local safeguarding service. Pharmacy team members had not completed any training on safeguarding. The pharmacist had completed training via The Centre for Pharmacy Postgraduate Education (CPPE) in 2018.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy team members are qualified and have the right skills for their roles and the services they provide. They undertake training regularly. They reflect on their own performance, discussing any needs with the pharmacist and colleagues. And they support each other to reach their goals. The pharmacy team members feel able to raise concerns and use their judgement. They can discuss issues and act on ideas to support the delivery of services. But they don't always establish and discuss specific causes of mistakes. So, they may miss chances to learn from errors and make changes to make things safer.

Inspector's evidence

At the time of the inspection, the pharmacy team members present were a locum pharmacist, two dispensers, a trainee dispenser and a delivery driver. Pharmacy team members advised theycompleted an online training module every few months. But, they could not access their records of training during the inspection. Modules covered various topics, which were often about seasonal conditions or new products. Pharmacy team members had completed a quiz testing their knowledge of the standard operating procedures (SOPs) in February 2019. And records of their successful completion were available.

The pharmacy had an appraisal process in place for pharmacy team members. A dispenser advised that during the appraisal, they had the opportunity to discuss areas where they felt they were doing well and areas for improvement. And, they set objectives to address any needs. One example of a recent objective set was for her to learn more about some over the counter products to help her give more effective advice to people about their medicines. She felt supported by teaching from the pharmacist and colleagues and by reading the patient information leaflets about medicines.

A dispenser explained that she would raise professional concerns with the pharmacist or area manager. She felt comfortable raising a concern. And confident that her concerns would be considered, and changes would be made where they were needed. The pharmacy had a whistleblowing policy. And, pharmacy team members knew how to access the procedure.

The pharmacy team communicated with an open working dialogue during the inspection. Pharmacy team members confirmed they were told by the pharmacist when they had made a mistake. The discussion that followed did not fully explore why they had made the mistake. And, changes proposed were often for them to be more careful.

Pharmacy team members explained a change they had made after they had identified areas for improvement. They had rearranged the prescription retrieval area by placing small bags of dispensed medicines in a basket on relevant shelf. This made them easier to find and meant that small packages did not get lost behind large ones.

The pharmacy owners asked the team to achieve targets. Targets included the number of patients who nominated the pharmacy to receive their electronic prescriptions and the number of prescription items dispensed. The pharmacy team were not aware of any consequences of not meeting a target other than losing their financial incentive at the end of the year.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean and properly maintained. It provides a suitable space for the services provided. And, it has a room where people can speak to pharmacy team members privately.

Inspector's evidence

The pharmacy was clean and well maintained. All areas of the pharmacy were tidy and well organised. And the floors and passage ways were free from clutter and obstruction. There was a safe and effective workflow in operation. And clearly defined dispensing and checking areas. It kept equipment and stock on shelves throughout the premises.

The pharmacy had a private consultation room available. The pharmacy team used the room to have private conversations with people. The room was signposted by a sign on the door.

There was a clean, well maintained sink in the dispensary used for medicines preparation. There was a WC which provided a sink with hot and cold running water and other facilities for hand washing.

Heat and light in the pharmacy was maintained to acceptable levels. The overall appearance of the premises was professional, including the exterior which portrayed a professional healthcare setting. The professional areas of the premises were well defined by the layout and well signposted from the retail area.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy is accessible to people. And it generally provides its services safely and effectively. It stores, sources and manages its medicines safely. The pharmacy team members dispense medicines into devices to help people remember to take them correctly. And they provide information with these devices to help people take their medicines safely. They identify people taking some high-risk medicines. And they provide people with advice.

Inspector's evidence

The pharmacy had level access from the street. It had a bell and sign to help people get staff attention if they needed help getting in to the pharmacy. But the bell was not working. The pharmacy provided large print labels to help people with a visual impairment and, pharmacy team members said they would communicate in writing with people with a hearing impairment.

Pharmacy team members signed the dispensed by and checked by boxes on dispensing labels. This was to maintain an audit trail of staff involved in the dispensing process. They used dispensing baskets throughout the dispensing process to help prevent people's prescriptions being mixed up. The pharmacy obtained medicines from three licensed wholesalers. It stored medicines tidily on shelves. And all stock was kept in restricted areas of the premises where necessary. It had adequate disposal facilities available for unwanted medicines, including controlled drugs (CDs). The pharmacy team kept the contents of the pharmacy fridge tidy and well organised. They monitored minimum and maximum temperatures in the fridge every day. And they recorded their findings. The temperature records seen were within acceptable limits. The pharmacy kept dispensed items stored in the fridge in clear plastic bags. Pharmacy team members said this was to help facilitate a final visual check of the product against the prescription by staff and the patient as the medicine was handed out. The pharmacy team kept the contents of the CD cabinet tidy and well organised. And, out of date and patient returned CDs were segregated. The inspector checked the physical stock against the register running balance for three products. And they were found to be correct.

The pharmacy supplied medicines in multi-compartmental compliance packs to people in their own homes. It provided descriptions of the medicines supplied on the packaging to help people identify the medicines in the pack. And each month the team supplied people with information leaflets about the medicines. The pharmacy team documented any changes to medicines provided in packs on the patient's electronic record. Pharmacy team members said that prescriptions for the nursing home were being sent to the company's hub dispensary. But, the first batch of prescriptions had been sent the previous week and had been dealt with by the pharmacist. So, they did not know they process for sending prescriptions to the hub or who was responsible for performing the relevant safety checks. They also did not know if there was a standard operating procedure for the process.

Pharmacy team members checked medicine expiry dates every 12 weeks. They kept records of their checks online. But, checks of over-the-counter medicines had not been completed since January 2019. They highlighted any short-dated items with a sticker on the pack up to three months in advance of its expiry. And they recorded expiring items on a monthly stock expiry sheet, for removal during their month before their expiry. The pharmacy responded to drug alerts and recalls. And, any affected stock found was quarantined for destruction or return to the wholesaler. The team recorded any action

taken, including details of any affected products removed.

People receiving prescription for sodium valproate were counselled by the pharmacist if appropriate. And, he said he would check if they were aware of the risks to pregnancy while taking the medicine. He said he would also check if they were on a pregnancy prevention programme. The pharmacy had some printed information material to give to people and to help highlight the medicine during dispensing.

Pharmacy team members were aware of the Falsified Medicines Directive (FMD) to help prevent counterfeit medicines. But, they did not know if the pharmacy had the right software or equipment in place to check products. There were no procedures and pharmacy team members had not been trained. So, the pharmacy was not complying with current law.

The pharmacy delivered medicines to people. It recorded the deliveries made and asked people to sign for their deliveries. The delivery driver left a card through the letterbox if someone was not at home when they delivered. The card asked people to contact the pharmacy to rearrange a delivery.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the necessary equipment available, which it properly maintains. And it manages and uses the equipment in ways that protect people's confidentiality.

Inspector's evidence

The pharmacy had the equipment it needed to provide the services offered. The resources available included the British National Formulary (BNF), the BNF for Children, various pharmacy reference texts and use of the internet. The pharmacy team obtained equipment from the licensed wholesalers used. And they had a set of clean, well maintained measures available for medicines preparation. They used a separate set of measures to dispense methadone.

The pharmacy kept sensitive information and materials in restricted areas. It positioned computer terminals away from public view. And they were password protected. It stored medicines waiting to be collected in the dispensary, also away from public view. And, it collected confidential waste in blue bags. The bags were closed when they were full. And they were collected and returned to head office for destruction. The dispensary fridge was in good working order. And the team used it to store medicines only. Access to all equipment was restricted and all items were stored securely.

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.