General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Village Pharmacy, 144B Burnley Road, Briercliffe, BURNLEY, Lancashire, BB10 2HJ

Pharmacy reference: 1092723

Type of pharmacy: Community

Date of inspection: 25/07/2019

Pharmacy context

This is a community pharmacy in a residential area of Burnley, Lancashire. The pharmacy sells over-the-counter medicines and dispenses NHS prescriptions. It also dispenses private prescriptions. The pharmacy team offers advice to people about minor illnesses and long-term conditions. And it offers services including medicines use reviews (MURs), flu vaccinations, the NHS New Medicines Service (NMS) and a NHS commissioned health check service. It also supplies medicines in multi-compartmental compliance packs to people living in their own homes.

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	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 adequate processes and written procedures to help protect the safety and wellbeing of people who access its services. It generally keeps the records it must have by law and keeps people's private information safe. It is adequately equipped to protect the welfare of vulnerable adults and children. The pharmacy team members discuss and learn from any errors they identify whilst dispensing.

Inspector's evidence

The pharmacy had an open plan retail area which led directly into the dispensary. It had a private consultation room to the side of the pharmacy counter. The pharmacist used the bench closest to the pharmacy counter to do final checks on prescriptions. This helped him supervise and oversee sales of over-the-counter medicines and conversations between team members and people.

The pharmacy had a set of standard operating procedures (SOPs) in place. These provided the team with information on how to perform tasks supporting the delivery of services. The SOPs covered procedures such as taking in prescriptions and dispensing. But the pharmacy did not have a SOPs covering the health check service. And so, the team members may not be clear about how they should carry out the process in a safe and consistent way. The team members were generally seen working in accordance with the SOPs. The pharmacy kept the SOPs in a ring binder. And there was an index which made it easy to find a specific SOP. The SOPs were reviewed every two years to make sure they were up to date. And the next recorded review date was July 2021. The pharmacy defined the roles of the team members in the SOPs. The team members said they would ask the pharmacist if there was a task they were unsure about. Or felt unable to deal with. All team members had read the SOPs relevant to their role. But it was unclear when they had done this.

The pharmacy had a process to report and record near miss errors that were spotted during dispensing. The pharmacist typically spotted the error and then informed the team member that they had made an error. The team members then discussed why the error had happened. The error was then rectified by the team member and then passed to the pharmacist for another check. The pharmacist then made a record of the error into a near miss log. The records contained details such as the time and date of the errors, but the team did not record why a near miss error might have happened. The team did not record details of each near miss error. And so, the team may have missed out on the opportunity to learn from their mistakes. No near miss errors had been recorded since February 2019. The pre-registration pharmacist demonstrated how the team had ensured that the dispensary shelves were kept tidy. Especially in the areas where medicine names sounded similar, e.g. amlodipine and atenolol. The pharmacy used a similar process to record and report dispensing incidents. The pharmacy recorded such incidents electronically and kept the records for future reference. The records were also sent to the company head office for analysis. The team had recently been made aware of an error involving the wrong strength of a medicine being dispensed. Although the team had discussed the incident, the pharmacy had not taken any action to prevent the error recurring.

The pharmacy did not advertise how people could make comments, suggestions and complaints. The pharmacy completed a feedback survey each year. It asked people who visited the pharmacy to complete a questionnaire. But the team members were unsure of the results of the latest survey. And

so, they may have missed the opportunity to improve the pharmacy's services.

The pharmacy had up-to-date professional indemnity insurance. The responsible pharmacist notice displayed the correct details of the responsible pharmacist on duty. Entries in the responsible pharmacist were not complete and the pharmacist had not signed in at the beginning of the day of the inspection. This was corrected as soon as the pharmacist was made aware. The controlled drug (CD) registers were completed correctly. Running balances were not checked regularly. For example, the pharmacy had not checked the balance of several CDs since 2018. Three random CD items were balanced checked. Each of the entries in the register matched physical stock. The pharmacy correctly used a CD destruction register to record patient returned medicines. It also kept complete records of supplies from private prescriptions and emergency supplies. Records of supplies of unlicensed medicines were often incomplete. This is not in line with requirements.

The team held records containing personal identifiable information in areas of the pharmacy that only team members could access. Confidential waste was placed into a separate container to avoid a mix up with general waste. The confidential waste was destroyed periodically. A privacy notice was on display in the retail area. And there was a leaflet available which explained to people how the pharmacy protected their personal information. The team members understood the importance of keeping people's information secure. And they had all signed confidentiality agreements.

The regular pharmacist had completed training via the Centre for Pharmacy Postgraduate Education on safeguarding the welfare of vulnerable people. The pharmacy did not have a policy on managing a safeguarding concern. And so, the team may not know how to effectively raise and manage a potential concern. A team member said she had completed some training in her previous employment. But there was no evidence to confirm this. The team member gave several examples of symptoms that would raise her concerns. And said she would discuss any concerns with the pharmacist on duty, at the earliest opportunity. The team members said that they would offer people to have their medicines dispensed in multi-compartmental compliance packs if they noticed they were struggling to remember to take their medicines correctly.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy team is small, and it has enough team members to manage the services it provides. The team members complete training when they can, to ensure their knowledge and skills are up to date. They tailor their training to help them achieve their personal goals. And they feel comfortable to suggest improvements to ways of working and to raise professional concerns when necessary.

Inspector's evidence

The pharmacy employed a small team. A locum pharmacist was on duty at the time of the inspection. And was supported by a pre-registration trainee pharmacist, a part-time pharmacy assistant and a full-time trainee pharmacy technician. The regular pharmacist and the delivery driver were not present during the inspection. The regular pharmacist was full-time and was covered by locum pharmacists on her days off. The team members said they felt they had an adequate number of team members to manage the dispensing workload. The team members did not take time off in the few weeks before Christmas. As this was the pharmacy's busiest period. The team members worked overtime to cover each other's absences. The pre-registration trainee pharmacist was due to finish his employment with the pharmacy at the end of the day of the inspection. A new pre-registration trainee pharmacist was scheduled to start employment the week after the inspection.

The pharmacist on duty supervised the team members. And they involved the pharmacist in offering advice to people who were purchasing over-the-counter products for various minor ailments. The team members were seen carrying out tasks and managing her workload in a competent manner. And they asked appropriate questions when selling medicines that could only be sold under the supervision of a pharmacist. The team members accurately described the tasks they could and could not perform in the pharmacist's absence.

The pharmacy did not provide its team members with a structured process for them to keep their knowledge and skills up to date. But it encouraged them to read literature about pharmacy services and products that the pharmacy received in the post. This helped them ensure they provided correct and relevant advice to people. The trainee pharmacy technician received time during the working day to train. The team members had recently completed training on head lice treatment. The pharmacy supported its team members with a performance appraisal on an ad-hoc basis. The appraisals were an opportunity for the team members to discuss what parts of their roles they felt they enjoyed and which parts they felt they wanted to improve. They were also able to give feedback on how to improve the pharmacy's services. And discuss their personal development. A pharmacy assistant said that she wanted to be able to give people better advice on healthy living while she was undergoing the health check service. The pharmacy arranged for the team member to attend a healthy living pharmacy course and become a qualified healthy living champion.

The team did not have regular, formal meetings. But as it was a small team, the team members discussed topics such as company news, targets and patient safety, when the pharmacy was quiet. If a team member was not present during the discussions, they were updated the next time they attended for work. The team members openly and honestly discussed any mistakes they had made while dispensing and discussed how they could prevent the mistakes from happening again. The pharmacist said the main risk in the pharmacy was the lack of space to dispense in. The team members agreed to

ensure they used baskets to hold prescriptions and medicines and to not let the baskets pile up to ensure they maximised the bench space.

The team members said they were able to discuss any professional concerns with the pharmacist or with the company head office personnel. They were not aware of a company whistleblowing policy. And so, the team may find it difficult to raise a concern anonymously. The pharmacy set several targets for its team to achieve. These included services and prescription volume. The team members said the targets were reasonable and achievable. And they were not under any pressure to achieve them.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean, secure and adequately maintained. It has a sound-proofed room where people can have private conversations with the pharmacy's team members.

Inspector's evidence

The pharmacy was clean and tidy. But there were several dismantled cardboard boxes stored near the main window. And this did not present a professional environment.

Floor spaces were clear with no trip hazards evident. There was a clean, and adequately maintained sink in the dispensary for medicines preparation and staff use. There was a WC which had a sink with hot and cold running water and other facilities for hand washing.

The pharmacy had a sound-proofed consultation room which contained two seats. The room was smart and professional in appearance. But the room was not signposted. And so, people may not know that a room was available for them to have private conversations with the team. The temperature was comfortable throughout the inspection. Lighting was bright throughout the premises.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides an appropriate range of services to help people meet their health needs. It obtains its medicines for licensed suppliers. And it generally stores and manages its medicines safely. The pharmacy identifies and manages its risks sufficiently to make sure it provides services safely and effectively. The team members help people to safely take high-risk medicines. They manage the risks associated with dispensing medicines in multi-compartmental compliance packs, but dont always give these people sufficient written information about their medicines.

Inspector's evidence

The pharmacy had a simple push/pull entrance door that was accessible via steps or a ramp from the street. The pharmacy advertised its services and opening hours in the main window. Seating was provided for people waiting for prescriptions. People could request large print dispensing labels. The team members had access to the internet. Which they used to signpost people requiring a service that the team did not offer. A wide range of healthcare related leaflets were available for people to select and take away.

The team members regularly used various stickers that they could use as an alert before they handed out medicines to people. For example, to highlight interactions between medicines or the presence of a fridge line or a controlled drug that needed handing out at the same time. The team members did not always sign the dispensing labels to indicate who had dispensed and checked the medication. And so, a robust audit trail was not in place. The dispensary had a manageable workflow with separate areas for the team members to undertake the dispensing and checking parts of the dispensing process. They used baskets to hold prescriptions and medicines. This helped the team members stop people’s prescriptions from getting mixed up. The team used different coloured baskets to indicate urgency and which prescriptions required delivery. The team didn't have a robust process to highlight the expiry date of CD prescriptions awaiting collection in the retrieval area. So, there was a risk of supplying CDs, that were not stored in the CD cabinet, after the prescription's expiry date. The importance of this was discussed with the pharmacist. Owing slips were given to people on occasions when the pharmacy could not supply the full quantity prescribed. One slip was given to the person. And one kept with the original prescription for reference when dispensing and checking the remaining quantity. The pharmacy kept basic records for the delivery of medicines from the pharmacy to people. It did not always get signatures from people to confirm they had received their medicines. And so, an audit trail was not in place to help solve queries. A note was posted to people when a delivery could not be completed. The note advised them to contact the pharmacy.

The pharmacy offered people an NHS commissioned health check service. The service incorporated blood pressure, diabetes and cholesterol level checks. The service was carried out by the trainee pharmacy technician. And she had received training to provide the service effectively. The team member also asked the person various health care related questions such as information about their diet and alcohol intake. The information gathered was translated into a final score. If the score was of a level which put the person at risk of developing a health condition, then the person was advised of this. And a copy of the consultation was sent to the person’s GP.

The pharmacy often dispensed high-risk medicines for people such as warfarin. And the team members

used alert stickers to help identify people receiving these medicines. The pharmacist often gave the person additional advice if there was a need to do so. But details of these conversations were not recorded on people's medication records. So, the pharmacy could not demonstrate how often these checks took place. INR levels were not always assessed in the pharmacy. The team members were clear about the requirements of the valproate pregnancy prevention programme. And they were aware of the risks. And they demonstrated the advice they would give people in a hypothetical situation. The team members had access to literature about the programme that they could provide to people to help them take their medicines safely. The team did a check to see if any of its regular patients were prescribed valproate. And met the requirements of the programme. The check did not identify any people.

The pharmacy supplied medicines in multi-compartmental compliance packs for people living in their own homes and in two local care homes. The team members completed the dispensing for these packs on a rear bench away from the pharmacy counter. This was done to prevent any distractions, such as people waiting to be served. The team members were responsible for ordering the person's prescription. And they did this around a week in advance, so they had ample time to manage any queries. And then the prescription was cross-referenced with the person's electronic medication record to ensure it was accurate. The team members queried any discrepancies with the person's prescriber. The team members supplied the packs with backing sheets with dispensing labels attached. And with information to help people visually identify the medicines. The pharmacy did not routinely supply the packs with patient information leaflets. This is not in line with requirements.

Pharmacy only medicines were stored behind the pharmacy counter. The storage arrangement prevented people from self-selecting these medicines. The pharmacy had a date checking schedule to be completed every six months and it used stickers to highlight short-dated stock. But it did not keep a record of the process. And so, an audit trail was not in place that could be used if there was a query. Some short-dated stickers were seen on the dispensary shelves. And no out-of-date stock was found during a random check. The team members recorded the date liquid medicines were opened on the pack. So, they could check they were in date and safe to supply.

The team members were not currently scanning products or undertaking manual checks of tamper evident seals on packs, as required under the Falsified Medicines Directive (FMD). No software or SOP were available to assist the team to comply with the directive. But scanners were installed. The team members had not received any training on how to follow the directive. The team were not sure when they expected to be compliant with the directive.

Fridge temperatures were recorded daily using digital thermometers. A sample of the records were looked at. And the temperatures were found to be within the correct range. But the thermometer was not functioning when it was tested during the inspection. The batteries were replaced following the inspection and evidence was seen that showed the thermometer was functioning correctly. The pharmacy obtained medicines from several reputable sources. Drug alerts were received via email to the pharmacy and actioned. But no records of the action taken following an alert, were available for inspection.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy's equipment is clean and safe to use. And the pharmacy adequately protects people's confidentiality.

Inspector's evidence

References sources were in place. And the team had access to the internet as an additional resource. The resources included hard copies of the current issues of the British National Formulary (BNF) and the BNF for Children.

The pharmacy used a range of CE quality marked measuring cylinders. And it had tweezers and rollers available to assist in the dispensing of multi-compartmental compliance packs. The fridge used to store medicines was of an appropriate size. And the medicines inside were organised in an orderly manner.

Prescription medication waiting to be collected was stored in a way that prevented people's confidential information being seen by members of the public. And computer screens were positioned to ensure confidential information wasn't on view to the public. The computers were password protected. Cordless phones assisted the team in undertaking confidential conversations.

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.