General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Central Pharmacy, Lintonville Medical Group, Lintonville Terrace, ASHINGTON, Northumberland, NE63 9UT

Pharmacy reference: 1093072

Type of pharmacy: Community

Date of inspection: 10/12/2019

Pharmacy context

This 100-hour community pharmacy is within a medical centre in Ashington, Northumberland. It dispenses NHS and private prescriptions and sells over-the-counter medicines. The pharmacy offers a prescription collection service from local GP surgeries. And it delivers medicines to people's homes. It supplies medicines in multi-compartmental compliance packs. These help people remember to take their medicines. And it provides NHS services such as a substance misuse service.

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 not all met	1.1	Standard not met	The pharmacy does not manage all risks. It is not clear which procedures are in use and the pharmacy team have not completed training on these or signed as read and understood.
2. Staff	Standards met	N/A	N/A	N/A
3. Premises	Standards not all met	3.1	Standard not met	There is insufficient space in the pharmacy to safely provide the services currently provided.
4. Services, including medicines management	Standards not all met	4.3	Standard not met	The pharmacy does not always store medicines appropriately. It does not routinely check and record fridge temperatures.
		4.4	Standard not met	There is no audit trail to provide assurance that all Medicine alerts and recalls are being actioned.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance **Standards not all met**

Summary findings

The pharmacy has some processes and procedures in place to protect the safety and wellbeing of people using its services. But the team members are unsure of their contents of the SOPs and which version to use. So they may not be working in a consistent manner. It keeps the records it must have by law. And these were mostly in order. And keeps people's private information safe. The team is equipped to help protect the welfare of vulnerable adults and children. The pharmacy team members respond when mistakes happen. And they discuss what happened and act to prevent future mistakes. But the reviews are limited so the team does not have all the information to identify patterns and learn from these.

Inspector's evidence

One of the regular pharmacists explained that the pharmacy had a set of paper standard operating procedures (SOPs). However, it was his understanding that these were being updated by the superintendent (SI). Many of these were not available. This was also the understanding of the accuracy checking technician. The pharmacist showed the inspector some SOPs which had been reviewed in July 2018. Most members had signed these in 2018. The SI arrived in the pharmacy after a member of the team had contacted her. She told the inspector that she had reviewed the SOPs, and these were available electronically. Members of the pharmacy team were not aware of this or of their location on the system. So it was not possible to review their contents.

There was a near miss record sheet. The checker having spotted the error let the team member know that they had made an error. The prescription was handed back to the dispensing assistant responsible to correct. And the checker recorded the error. There were usually around ten to twenty near misses recorded each month. There was no space on the sheet to record why the error had occurred and what changes had been made to prevent a re-occurrence of the error. The amount of detail recorded was basic. And did not provide enough information to make meaningful change. The ACT advised that the SI did a periodic review of the errors. But was unable to find these. The ACT advised that the pharmacist deals with dispensing errors initially. And reported these to the SI. There was a file which contained the error reporting forms for dispensing errors. The SI said that they are also recorded dispensing errors electronically. The inspector looked at six error reports and, in each case, it was noted that no further action was taken. And there were no areas noted for change. The SI said that although no actions were recorded, she does speak to members of the pharmacy team when an error occurs. She advised that the pharmacy was laid out by BNF category and she considered that this reduced the risk of selecting the wrong item from the shelves.

The pharmacy had a complaints policy. And there was a laminated copy displayed near the pharmacy till. The SI advised that some delivery patients had expressed their dissatisfaction that they were not given a time when their medicines would be delivered. The pharmacy had supplied a letter to all delivery patients explaining the process. And while they tried their best the pharmacy could not guarantee a time. The approach appeared to be successful and there were less complaints about deliveries.

Appropriate professional indemnity insurance was in place. The responsible pharmacist (RP) notice displayed the correct details of the responsible pharmacist on duty. Entries in the responsible

pharmacist record were not completed in all cases and there were regular blanks in the register. For example, the pharmacist on the day was not signed in and there was an omission the previous day. The records demonstrated that running balances were not being completed regularly. Two random balance checks of stock in the CD cabinet did not tally with the entry in the CD cabinet. The SI contacted the inspector to confirm that the discrepancies were down to recording errors and the balances were now correct. The pharmacy retained records of private prescription and emergency supplies. The pharmacy retained completed certificate of conformities following the supply of an unlicensed medicine, including patient details.

The team held records containing personal identifiable information in staff only areas of the pharmacy. Confidential waste was placed into a separate bin to avoid a mix up with general waste. The confidential waste was destroyed off site. The pharmacist had done information governance training with the pharmacy team members during staff induction. There was a record that confirmed that the pre-registration student had completed GDPR training in July 2019. And a member of the pharmacy team explained that they had a cordless telephone which allowed them to have private conversations with people without being overheard. The registered team members had completed Level 2 training on safeguarding. The SI had spoken to the rest of the team about safeguarding vulnerable adults and children. A pharmacy team member said that they would discuss any concerns with the SI, who works some days. Or if it was urgent with the pharmacist on the day.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy team members have the right qualifications for their roles and the services they provide. The team are supported when training. They work together as a team in an open and honest culture. And they are empowered to offer suggestions for the change for the benefit of people that access the pharmacy services. The pharmacy team do not always work in a consistent manner. A regular appraisal would be helpful for the team to discuss any training needs or issues that they are concerned about.

Inspector's evidence

The inspector noted that there appeared to be adequate members of staff to handle the workload on the day. However, the very small pharmacy made working efficiently difficult. At the time of the inspection there was one of the regular pharmacists, two ACTs, three dispensers. And a pre-registration pharmacy student. The pre-registration student and the trainee technician were given dedicated study time each week. Holidays were planned in advance. And members of the pharmacy team worked extra hours if necessary. The SI confirmed that three previous members of staff worked on a locum basis to cover team members holidays or when the pharmacy was very busy.

The SI had a training file for members of the pharmacy team. The SI advised that the pharmacy team did training when the GP practice in the medical centre had a half day training event each month. Recent training completed included first aid training. And the certificates were displayed on the walls. Some pharmacy team members were unsure of the contents of the SOPs. For example, some were unsure about error reporting. And basic tasks such as fridge temperature recording. And what to do when the temperatures were outside of the accepted range. The SI said that the pharmacy team did not receive formal written appraisals. She said that this was because of the lack of time. The SI confirmed that she does give on the spot feedback.

The pharmacy was open for 100 hours and communication could sometimes be a problem. The SI advised that there was a what's app group set up. And this allowed the team to note any issues and was useful for handing over information. The pharmacy team thought that the SI was approachable and receptive to any suggestions to improve the service offered to people. The team members said that they shared ideas for improvement to the service offered. For example, the team had suggested a change in the way the delivery sheet was laid out. To make the system more streamlined. The change had made it easier for the driver to plan the delivery route. The team were unsure if there was a whistleblowing policy. But they said that they would go to one of the pharmacists if they had a concern. Or to the SI if need be. There was also an option to speak to one of the Directors. No targets were set for services. The pharmacy team members thought that people valued the services offered and they always tried to provide these.

Principle 3 - Premises **Standards not all met**

Summary findings

The pharmacy has limited available working space on the pharmacy benches. And the shelves and storage space are full to capacity. The pharmacy team members manage this as best as they can. But the pharmacy premises and layout are not adequate for the volume of work. And increases risk. The pharmacy is secure when the pharmacy is closed and adequately maintained. It has a sound-proof room where people can have private conversations with the pharmacy's team members.

Inspector's evidence

The pharmacy was situated in health centre. When the health centre was closed the pharmacy provided services through a hatch to the front. The pharmacy was accessible for wheelchair users. The pharmacy was small and thin. And the layout made it difficult to work in. People had to turn sideways to pass each other. And because the pharmacy was long and thin this happened often. There was a comfortable shared waiting area for patients. The area for preparing multi-compartmental compliance packs was small and there was insufficient space for storing the completed packs.. There was a consultation room which was separate from the pharmacy. It was adequately sized and signposted. And it was sound proofed. There was a desk, chairs and computer. There were lockable cupboards in the consultation room. There were very limited stock storage areas. The pharmacy shelves were overcrowded. and stock was falling into each other. Working areas were cluttered. And the pharmacy team found it difficult to find a space to work in. The pharmacy shelves, benches and flooring were reasonably clean. There was a retrieval area which was inadequate and there were a number of totes on the floor with completed prescriptions waiting for collection. These obstructed the narrow walk way and made access to stock on the shelves difficult. The sink for preparation of medicines was clean. And there was hot and cold running water. The room temperature was comfortable.

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

Summary findings

The pharmacy helps people to ensure they can all use its services. The pharmacy does not always provide safe services. This is due to some team members not being aware of the new versions of the SOPs or where they are kept. And the team had received no training on these. The pharmacy gets medicines from reliable sources. But it does not always store them appropriately.

Inspector's evidence

There was direct access into the pharmacy for people in wheelchairs and for those with mobility problems. The pharmacy advertised its services in the pharmacy. The opening hours were also displayed. A range of healthcare related leaflets were available for people to select and take away.

People could request multi-compartmental compliance packs. And these were supplied to people to help them take their medicines at the right time. Because of space restrictions the pharmacy was not accepting any more multi-compartmental pack patients.

The pharmacy kept records and signatures of receipt for the delivery of all drugs from the pharmacy to people. There was a date checking procedure. And the matrix indicated that date checking had last been completed in July. The team used stickers to highlight medicines that were expiring in the next six months. The inspector checked two locations on the pharmacy shelf. And found Almoram 12.5mg which was out of dare in September 2019. So, these were unfit to supply to people. And the inspector removed them for destruction. The shelves were untidy. It was noted that there had been an error when the wrong strength of Quetiapine was supplied. The different strengths were mixed together on the shelves. Increasing the risk of a picking error. Other medicines such as sodium valproate were similarly mixed together. The pharmacy team said that it was difficult to separate medicines because there wasn’t enough space on the shelves. An audit trail was in place for dispensed medication using dispensed by and checked by signatures on label. Baskets were available to hold prescriptions and medicines. This helped the team to stop people’s prescriptions from getting mixed up.

The pharmacy did not have a process for routinely identifying and counselling those patients on high risk medication. Discussions with people took place opportunistically. So, the pharmacy could not demonstrate how often these checks took place. The team were aware of the pregnancy prevention programme (PPP) for people who were prescribed valproate. The SI had completed an audit to identify eligible people. She confirmed that there were two eligible patients. And the audit results were in the file in the pharmacy. And all the relevant information was provided. The PMR records were not looked at. There was a sodium valproate patient pack in the pharmacy. The pharmacy team were not currently scanning products or undertaking manual checks of tamper evident seals on packs, as required under the Falsified Medicines Directive (FMD). The software had been updated. But there were no SOPs in place. And the pharmacy team confirmed that they had not yet received training. Fridge temperatures were not always recorded and there were omissions in the electronic records. The SI thought that the temperature was being checked every morning but were not being entered onto the electronic record. The pharmacy obtained medicines from several reputable sources such as AAH, Alliance and DE. And invoices were retained. Drug alerts were received electronically these were printed off and actioned. And then they were discarded. So, there was no audit trail to provide assurance that the alert had been

actioned.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy's equipment is clean and safe, and the pharmacy uses it appropriately to protect 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. A methameasure was used to pump methadone. And this was cleaned and calibrated daily. Tweezers and gloves were available to assist in the dispensing of multi-compartmental packs. The pharmacy had a first aid kit. The fridge used to store medicines was of an appropriate size. 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 in undertaking confidential conversations. Members of the pharmacy team had their own NHS smart cards. And these were being used appropriately.

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.