General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: 4 Court Pharmacy, Blackburn Service Station, Whalley Banks, BLACKBURN, Lancashire, BB2 1NT

Pharmacy reference: 1093283

Type of pharmacy: Community

Date of inspection: 27/01/2020

Pharmacy context

The pharmacy is on a service station forecourt on a main road close to the centre of town. It opens extended hours seven days a week. It mainly dispenses NHS prescriptions and sells over-the-counter medicines. It provides a substance misuse service. It supports some people by dispensing their medicines into multi-compartment compliance packs. And it delivers people's medicines to them at home. The pharmacy provides a range of services including seasonal flu vaccinations.

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	4.3	Standard not met	The pharmacy doesn’t store all the medicines needing safe custody as it must by law. And it doesn't keep all medicines under the direct supervision of a pharmacist at all times, as required.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance ✔ Standards met

Summary findings

The pharmacy mostly identifies and manages the risks with its services. It listens to people's feedback and makes improvements to its services to help keep the community safe. The pharmacy keeps people's private information secure. Pharmacy team members help protect the safety and wellbeing of vulnerable people. They record mistakes that happen during dispensing. And they informally discuss how to prevent similar mistakes happening in the future. The pharmacy has written procedures to help the team work safely and effectively. But not all the details in these procedures are complete. And the team doesn't always follow all the steps in some of these procedures.

Inspector's evidence

The pharmacy had a set of standard operating procedures (SOPs) branded as Alphega and mostly specific for the pharmacy's services. There were SOPs for dispensing processes, controlled drug (CD) management, multi-compartment compliance pack dispensing and the Responsible Pharmacist (RP) regulations. The pharmacy had recorded the last SOP review as September 2018. The team members had signed to confirm reading the SOPs in September 2018, just after the review. And the pre-registration pharmacist had read them when he started working in the pharmacy. The team members had signed one record to confirm they had read all the SOPs. But they were meant to complete a signature sheet for each SOP, according to the paperwork. The pharmacy hadn't recorded the date of preparation and date of review on each individual SOP as designed. So, it had no record of the reviews of the individual SOPs. And who had done this and when. The pharmacy kept several duplicated SOPs in the file, but as there was no date on any of these it was difficult for the team members to know which ones to refer to. The newest member of team who had just started and the driver had not signed to evidence they had read the SOPs. The pharmacy provided the Community Pharmacist Consultation Service (CPCS) but it didn't have a SOP for the service in the file. The pharmacy team was not following all aspects of the SOPs, such as completing weekly CD balance checks. Some aspects of the date checking SOPs didn't align to the process that the team was following. For example, splitting the date checking into twelve sections.

The pharmacy recorded near-miss errors on a paper record. The form didn't have sections to complete for what was prescribed and what was dispensed. So, on many occasions it was difficult to understand what the error had been. And this made it more difficult to spot trends. The pharmacy team recorded some near-miss errors each month. This was seen on the current form and on previous forms retained for reference. The pharmacy hadn't any recent completed near-miss review forms. The pharmacist described how the team discussed the errors they had made, informally without making a record. Some of the pharmacy team had completed training about look-alike and sound-alike (LASA) medicines. The team members had separated some medicines on the shelves to help prevent selection errors. And they had attached some alerts to the dispensary shelves. For example, highlighting ramipril capsules and tablets. The pharmacy had a process and form for recording any dispensing incidents. It had no records of any incidents since 2017.

The pharmacy displayed the correct Responsible Pharmacist notice. It had a roles and responsibilities task matrix template, but this was not complete. Other details in the RP SOPs, specific to the pharmacy, were not complete. The pharmacy team members were working within their roles and competences during the inspection. The team members appropriately gave advice and referred people to the

pharmacist when they needed to.

The pharmacy had a complaint's form to help the team members record details of any complaints. And historical forms were kept for reference. The pharmacy had a written complaints procedure, but not all team members were aware of the procedure. The team members knew how to try and resolve a concern themselves and described how they would refer serious concerns to the pharmacist. The pharmacy asked people to feedback using an annual questionnaire. It displayed the results of the 2017-2018 survey on the NHS website, but not in the pharmacy. The pharmacy had responded to the areas for improvement in the last survey as it had a dedicated area for information about healthy living and it displayed a large stop smoking poster in the window. A team member described how she signposted people to the healthy living area, which was also the seating area for waiting for prescriptions. The pharmacy had suspended the substance misuse needle exchange following feedback from the local community businesses, who had found needles in the local area. Conversations and engagement with the people using the service hadn't stopped it, so the pharmacy had suspended the service to ensure people in the community were safe. The pharmacy advertised the suspension of the service in the substance misuse pick-up area of the pharmacy.

The pharmacy kept the RP records on a monthly sheet, rather than in a bound record book or on the computer. It kept historical records. There was no space on this record to document absences of the RP, should there be any. And the actual date wasn't recorded. It was implied, as the top of the form stated the week commencing date and the form then detailed Monday to Sunday. Records for private prescriptions mostly complied with requirements. But details of the prescribers were not recorded on the print outs of the register. The pharmacy kept an electronic CD register and the records generally met the requirements. The full details of the prescriber were not always recorded. Some balance checks of the physical quantity against the register entry were completed in the electronic register. And some were hand written in a notebook and signed by a witness to confirm these had been done. Mostly the pharmacist recorded checks after each dispensing and then completed a full check on CDs monthly. The SOP for CD balance checks indicated these were to be completed weekly. So, the team were not following the SOP. It was difficult to see when the pharmacy had last checked the balance for methadone and a record of this wasn't seen in the sample checked. The pharmacist described how they checked it on a Friday before they started pre-preparing the week's methadone supplies. But a record wasn't made. A check on methadone 5mg tablets and Morphgesic 30mg s/r tablets confirmed the register entry matched the physical stock quantity. The pharmacy kept records associated with the supply of unlicensed medicines in accordance with the requirements of the Medicines & Healthcare products Regulatory Agency (MHRA).

The pharmacy had documents in a file relating to Information Governance and General Data Protection Regulation (GDPR). But there was no training record or signature sheets to indicate that the team members had read them. The pharmacy had a shredder to dispose of confidential waste. And the pharmacist described how the team separated larger volumes of confidential waste and then stored it in sealed sacks before it being removed by a third party. There were no sacks available for use at the time of the inspection. The pharmacy was separating confidential waste. A team member showed some awareness of how to prevent conversations being overheard, by offering the use of the consultation room. The pharmacy had a privacy notice and NHS leaflets describing how people's data was handled.

The pharmacy had some information about safeguarding children and vulnerable adults in the training file. The pre-registration pharmacist hadn't yet completed any formal training. He had some knowledge of the importance of safeguarding. The regular pharmacists had completed the CPPE Level 2 safeguarding course in 2019. And the RP was fully aware of his role. He described how he worked closely with prescribers and the substance misuse team. The pharmacy had the contact details of the

local safeguarding team contacts clearly displayed close to the substance misuse pick up area.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has team members with appropriate qualifications and skills to provide the pharmacy's services. And they work well together to manage the workload. They feel comfortable suggesting ideas and raising concerns should they need to. They complete some ongoing learning relevant to their roles. But not all team members receive formal feedback about their performance. So, they may miss opportunities to improve.

Inspector's evidence

During the inspection the RP was a pharmacist manager. He had a pre-registration pharmacist, a part-time dispenser, a part-time medicines counter assistant and a new starter (in January), who had yet to be enrolled on a GPhC accredited course, supporting him. Another full-time dispenser, part-time dispenser, part-time medicines counter assistant and three delivery drivers worked at the pharmacy but weren't present during the inspection. The pharmacy had another pharmacist manager and employed regular locums to cover when needed. The pharmacy opened extended hours and the pharmacist described how the team ensured there was two or more staff working in the pharmacy to cover the opening hours. The team members covered each other when necessary. And the pharmacist managers organised any rota changes. The pharmacist described how due to the pharmacy's extended hours and the planned workload there were fewer challenges organising the staff rota. The team members were observed managing the workload in an organised manner during the inspection.

The pre-registration pharmacist had completed his thirteen week appraisal. He felt supported with his studies. And he discussed learning opportunities during the working day with the RP and with his tutor. He completed his own learning relevant to the pre-registration year. And the pharmacist described how he also completed the same learning as the other team members. A learning need associated with safeguarding was identified during the inspection. The pharmacy had a training information file, that team members used to upskill their knowledge. They read new information prior to changing the health promotion material in the pharmacy's healthy living zone. This meant they could keep their knowledge up to date and be more informed to discuss healthy living topics with people coming into the pharmacy. The pharmacy had recently set up a team training and appraisal file. But the team members had no records in the file as yet. The team members were seen completing their tasks in a competent way during the inspection. And referring people to the pharmacist appropriately. A person requested information regarding a potential allergy they had. The medicines counter assistant asked appropriate questions before referring the person to the pharmacist, who took the person into the consultation room. The regular pharmacists had completed training relevant to their roles and the services provided. These included training relating to safeguarding, LASA medicines and sepsis. They had completed relevant training to provide flu vaccinations and smoking cessation advice.

The team knew how to raise concerns. The pre-registration pharmacist described how he would first attempt to resolve any concern he had within the team. He felt comfortable in raising any concerns and suggesting ideas to the regular pharmacist managers. He was aware of how he could escalate a serious professional concern. The pharmacist was under no pressure to meet targets. He used his professional judgement to provide services to people.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is secure and generally clean and tidy. It offers a suitable environment for the pharmacy's services. The pharmacy has suitable areas for people to access services and have a private conversation with the pharmacist.

Inspector's evidence

The pharmacy was overall clean and generally properly maintained. It had two entrances for people. A main entrance off the forecourt and a separate entrance for the substance misuse service. The people gained admittance to this separate area using a buzzer. The team released the door to allow admittance. This area had some litter left by people using the service and was generally scruffy with scuff marks on the wall. There was some relevant information relating to the services provided in this area. But overall its appearance wasn't fully professional. The retail area portrayed a more professional appearance. There was a pharmacy counter and a separate hand out area. This meant the pharmacist could speak with people away from the pharmacy counter and protect their privacy. The positioning of the pharmacy counter prevented people from accessing the staff only areas of the pharmacy.

The pharmacy had enough bench and storage space for the workload. It stored its medicines appropriately on shelves throughout the premises. And the benches were clear from clutter. There were no slip or trip hazards. The temperature and lighting throughout the premises was sufficient, apart from a lighting fault in the healthy living zone making this area dark. The pharmacy had toilet facilities with hot and cold running water. But the pharmacy kept the sealed medicinal waste bins in this area. There was room in the rear dispensing area for these bins. The pharmacy had a sink in the back dispensing area with hot and cold running water for staff use and medicines preparation. These two activities were kept separate.

The pharmacy had an adequately-sized sound proof consultation room suitable for the services offered, with seating for people. It didn't have a computer terminal in the room. People accessed the room from the retail area. There was a separate entrance from the rear dispensing area for use by the pharmacy team. Neither of the doors were locked during the inspection. But the risk of unauthorised access to these areas was restricted by the positioning of the room and the presence of team members in these areas.

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

Summary findings

The pharmacy obtains its medicines from licenced sources. But it doesn't manage all its medicines as it should. And it doesn't have appropriate safe storage requirements for all its medicines. The pharmacy advertises its services and makes them accessible for people. And it manages and delivers its services safely and effectively. The team supports people taking high-risk medicines by providing them with advice and extra support. It delivers medicines to people's homes and gets people to sign for their medicines. So, the team has an audit trail in case of queries.

Inspector's evidence

The pharmacy premises had level access from the garage forecourt outside. The pharmacy was set to one side from the garage and there was some parking for cars outside the pharmacy. The pharmacy advertised its opening times and services in the window. It opened extended hours and seven days a week. The pharmacy had a range of leaflets and posters advertising services displayed in the retail area. And it displayed information relevant to the substance misuse service in the separate pick up area. For example, a poster about hepatitis C and the local drug and alcohol service contact details. The pharmacy had a dedicated healthy living zone that was clearly signposted. This was also the seating area for people waiting for their prescriptions. The team member explained how usually this encouraged people to read the information on the posters on the healthy living notice board and to pick up the reading material to take away. The information displayed related to stress management and signs and management of sepsis. The area was dark, the pharmacist explained there was an intermittent fault with the lighting in this area that hadn't been resolved. The pharmacy provided a flu vaccination and a smoking cessation service and had up-to-date patient group directions (PGD) and service specifications for these services.

The pharmacy had two dispensing areas, one to the side of the pharmacy counter. And a further area to the rear of the premises. The pharmacy completed a small amount of wholesale dealing in this back area. This was clearly separated with prominent notices on the wall. The pharmacy didn't wholesale supply fridge lines or CDs. The pharmacy team members used baskets throughout the dispensing process, to help reduce the risk of error. They kept a dispensing audit trail as the team members signed the dispensed by and checked by boxes on the dispensing labels. The pharmacy had an organised workflow, with separate areas for labelling, dispensing and checking prescriptions. It used clear bags for fridge lines and CDs to enable a further check of these higher risk medicines before handout. The pharmacist and members of the team were aware of the requirements of the valproate safety alert. And the requirement for people at risk to be on a pregnancy prevention programme. The pharmacist had identified two people who met the criteria after completing an audit. The results of the audit were kept for future reference. He had spoken with both people to support them and provide advice. Both were on a pregnancy prevention programme. He documented the date of the last specialist referral so he could determine when was the appropriate time to speak with them in the future. He explained how he checked, on each dispensing, that the person received a patient information leaflet and the warning card that was embedded in the original pack. If the person didn't receive their valproate in the manufacturer's original pack, he described how he provided a separate card from stock. The pharmacy kept a stock of valproate alert cards on the pharmacy counter for people to pick up.

The pharmacy provided medicines in multi-compartment compliance packs to help approximately

seven to eight people per week take their medicines. Each person had a medication record sheet indicating which medicines were to be dispensed into the packs and at what times. When the person had a change in their medication the team member updated the record and signed and dated the change. So, the pharmacy had an audit trail of changes. The pharmacy team members annotated the descriptions of the medicines on the packs. And they supplied patient information leaflets (PILs) monthly. The pharmacy provided a home delivery service, and this accounted for a high proportion of how people received their medicines. Due to the pharmacy's location away from GP surgeries, less people came into the pharmacy to collect their medicines The pharmacy kept a record of the deliveries and the driver obtained people's signatures on receipt of delivery. The pharmacy had an additional sheet for CDs. The driver posted some medicines and the pharmacist described how the team obtained verbal consent and checked it was safe. But the team didn't obtain written consent or make a record of the consent obtained on the patient's medication record (PMR).

The pharmacy had a popular substance misuse service. It dispensed people's methadone doses once a week in advance when the pharmacy was quiet to reduce the risk of errors. The team used a pump to improve the efficiency of dispensing the doses. But it kept people's pre-prepared doses all together in one container, so there was a risk of incorrectly selecting a person's dose. The pharmacist reduced the risk of this error by checking the day's daily doses against the prescriptions and then storing each person's dose separately. The Pharmacy (P) medicines were stored behind the pharmacy counter, so the pharmacist could appropriately oversee sales. The pharmacy counter provided a barrier in between the retail area and the dispensary to prevent unauthorised access into staff only areas. So, medicines were kept securely. The pharmacy obtained medicines, medical devices and unlicensed specials from licensed wholesalers. The pharmacy stored its medicines requiring cold storage in a medical fridge and kept a daily record of fridge temperatures. The records showed the fridge temperature was kept within the required range. But the temperature range on the thermometer in the fridge had recorded a maximum of 10 degrees Celsius. So, the records didn't match the thermometer readings. The temperature was within the required temperature during the inspection. The pharmacist planned to complete further checks of the temperature as reassurance that the fridge was in good working order. The pharmacy didn't store all of its medicines in safe custody, as required by law.

The pharmacy team completed date checking of the dispensary and retail stock. The pharmacist described how the team used stickers to highlight short-dated stock. No out-of-date medicines were found on shelves in the dispensary from the sample checked. But several short-dated stock items didn't have stickers attached. The pharmacy team had removed some medicines from the original manufacturer's pack but not appropriately labelled the containers with the batch number and expiry date. These were removed from the shelves. The pharmacy team didn't annotate all the packs of liquid medication with the date opened. So, the team wouldn't know if these medicines were fit to use. The pharmacy didn't have the equipment, such as scanners, to comply with the Falsified Medicines Directive (FMD). The pharmacy was aware of the requirements but hadn't a planned date to comply. The pharmacy had medicinal waste bins available for returned medication. But the team stored the sealed bins in the toilet. The pharmacy had appropriate processes to action medicine recalls and safety alerts. The team signed and dated printed copies of the alerts as an audit trail of their actions.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has most of the equipment and facilities it needs for providing its services. Pharmacy team members use them in a way which mostly protects people's confidentiality.

Inspector's evidence

Pharmacy team members had access to up-to-date reference resources. And they used the internet to access up-to-date clinical information. The main dispensary computer had the electronic medicines compendium page open during the inspection to access up-to-date clinical information. The computers were password protected and located in the dispensary. So, people's private information was protected. The pharmacy stored medication awaiting collection to the side of the pharmacy counter. People in the retail area couldn't see people's names and addresses on these medication bags. The pharmacy had a telephone with a portable hand-set, so the team could take private conversations in the back dispensing area. The pharmacy kept some completed consent forms and other information containing people's private details in box files on the back shelves of the consultation room. These were fairly inaccessible but were not locked away so there was a slight risk of unauthorised access if people were left alone in the consultation room.

The pharmacy had a fridge of a suitable size. The team used single-use equipment for dispensing into compliance packs and stored these appropriately. The pharmacy had some clean glass crown-stamped measures for pouring liquids. But one of the measures the team used was a plastic measure, which may not measure the liquids accurately. The pharmacy didn't have a full range of measures. And the team would find it difficult to accurately measure smaller volumes as they didn't have any smaller volume measures, such as 10ml measures. There was no evidence of electrical safety testing, but the electrical wiring was free from wear and tear. The pharmacy used a methadone pump and calibrated it each week before use.

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.