General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Blackwell Pharmacy, 6 Gloves Lane, Blackwell, ALFRETON, Derbyshire, DE55 5JJ

Pharmacy reference: 1094404

Type of pharmacy: Community

Date of inspection: 27/01/2020

Pharmacy context

This community pharmacy is located next to a medical centre in the centre of the village. Most people who use the pharmacy are from the local area. The pharmacy dispenses NHS prescriptions and sells a range of over-the-counter medicines. It supplies a large number of medicines in multi-compartment compliance aid packs to help people take their medicines at the right time. The pharmacy has a private travel clinic which offers vaccinations and medication to prevent malaria.

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	1.2	Good practice	The pharmacy records and analyses adverse dispensing incidents to identify learning points which it incorporates into day to day practice to help manage future risks.
2. Staff	Good practice	2.2	Good practice	The team members have the appropriate skills, qualifications and competence for their role and the pharmacy supports them to address their ongoing learning and development needs.
		2.4	Good practice	The pharmacy team work well together. Team members communicate effectively and openness, honesty and learning is encouraged.
3. Premises	Standards met	N/A	N/A	N/A
4. Services, including medicines management	Standards met	4.2	Good practice	The pharmacy proactively manages its services to ensure effective care and to help achieve improved outcomes for local people.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance ✔ Standards met

Summary findings

The pharmacy effectively manages risks to make sure its services are safe, and it acts to improve patient safety. It completes the records that it needs to by law and asks its customers for their views and feedback. Members of the pharmacy team work to professional standards and are clear about their roles and responsibilities. They have written procedures on keeping people's private information safe and understand how they can help to protect the welfare of vulnerable people.

Inspector's evidence

The pharmacy had standard operating procedures (SOPs) for the services provided, with signatures showing that all members of the pharmacy team had read and accepted them. The pharmacist superintendent (SI) confirmed that the SOPs were in the process of being reviewed to include new procedures, such as the scanning of medicines in line with the Falsified Medicines Directive (FMD). Roles and responsibilities were set out in the SOPs and the pharmacy team members were performing duties which were in line with their role. They were wearing uniforms and name badges. There was a notice on display in the pharmacy with the names and roles of the different members of the pharmacy team. The name of the responsible pharmacist (RP) was displayed as per the RP regulations.

Dispensing incidents were reported and learning points were included. Following an incident when gabapentin had been supplied instead of pregabalin, the team had been advised to take extra care when selecting and checking these two medicines. This incident had been reported on the National Reporting and Learning system (NRLS) website and a copy of the report retained in the pharmacy. Near misses were reported and discussed with the pharmacy team. These were reviewed by the SI each month and a monthly patient safety review was completed. Actions taken to prevent reoccurrences were documented. There had been a couple of near misses when the incorrect strength of sildenafil had been selected. The SI had advised the team to take extra care when dispensing medicines to ensure the correct strength was selected. 'Check name and strength' stickers were placed in front of look-alike and sound-alike drugs (LASAs) so extra care would be taken when selecting these. Daktacort and Daktarin cream and ointment had been highlighted. Clear plastic bags were used for assembled CDs to allow an additional check at hand out. E-mails were received from head office with shared learning from other pharmacies in the group and medicines at higher risk of error were highlighted. For example, photographs of medicines in similar packaging were shared.

There was a dealing with complaints SOP. A notice was on display in the pharmacy with the complaint's procedure and the details of who to complain to and this was also outlined in the practice leaflet. A customer satisfaction survey was carried out annually. The results of the most recent survey were on display and indicated that all respondents had rated the pharmacy very good or excellent. More detailed results from the 2018 survey were available on www.NHS.uk website. Areas of strength (100%) included the time taken to provide the prescription or service, the service received from the pharmacist, and the staff being polite and taking the time to listen. An area identified which required improvement (3% dissatisfied) was being able to speak without being overheard. The pharmacy's response was to highlight that it had a private consulting room available with a sign informing customers of its availability. It stated it would aim to advertise the availability of a private area with a sign at the customer counter. The SI said he had increased the numbers of chairs in the pharmacy

following feedback.

Insurance arrangements were in place. A current certificate of professional indemnity insurance was on display in the pharmacy. Private prescription and emergency supply records, the RP record, and the controlled drug (CD) register were appropriately maintained. Records of CD running balances were kept and these were regularly audited. Two CD balances were checked and found to be correct. Patient returned CDs were recorded and disposed of appropriately.

All members of the pharmacy team had read and signed information governance (IG) SOPs and completed training on the General Data Protection Regulation (GDPR) which included information about confidentiality. Confidential waste was collected in a designated place and sent to head office for disposal. A dispenser correctly described the difference between confidential and general waste. Assembled prescriptions awaiting collection were not visible from the medicines counter. Details about how the pharmacy complies with the GDPR and the NHS Code of Confidentiality was given in 'How we look after and safeguard information' leaflets, which were on display. An IG audit had been completed and these leaflets had been updated to include the option to opt out of sharing information with the NHS.

The SI and pharmacy manager had completed the Centre for Pharmacy Postgraduate Education (CPPE) level 2 training on safeguarding children and vulnerable adults. Other staff had completed a 'Virtual Outcomes' training module on safeguarding. A dispenser said she would voice any concerns regarding children and vulnerable adults to the pharmacist working at the time and was aware of the location of the safeguarding file which included policies and the contact numbers of who to report concerns to in the local area. The pharmacy had a chaperone policy, and this was highlighted to patients. All members of the pharmacy team had completed Dementia Friends training, so had a better understanding of patients living with this condition.

Principle 2 - Staffing ✔ Good practice

Summary findings

The pharmacy team members receive training for the jobs they do and the pharmacy supports and encourages them to develop their skills and keep their knowledge up to date. They work well together and communicate effectively. They are comfortable providing feedback to their manager and receive feedback about their own performance. The pharmacy enables the team members to act on their own initiative and use their professional judgement to the benefit of people who use the pharmacy's services.

Inspector's evidence

The SI was working as the RP. He explained that he usually worked one and a half day days each week in the pharmacy. A pharmacist manager covered the other days. There were two NVQ2 qualified dispensers (or equivalent) on duty at the time of the inspection and the staffing level was adequate for the volume of work during the inspection. The team were observed working collaboratively with each other and the patients. There were two additional qualified dispensers who were in the pharmacy team, although not present at the inspection. There was a holiday chart and planned absences were organised so that not more than one person was away at a time. Unplanned absences were covered by re-arranging the staff hours. Team members were mainly part time so there was flexibility.

Members of the pharmacy team carrying out the services had completed appropriate training and used various sources to ensure their training was up to date. For example, Virtual Outcomes which provided online training and supported NHS England public health campaigns such as oral health. Training records showing what had been completed for each member of staff were available. Regular team meetings were held at lunch times when the pharmacy was closed. Agendas were printed off and displayed. Review of near misses and training took place during these meetings and action points were recorded. The previous meeting contained a training session on sepsis. Earlier in the year a team from Bolsover NHS had been to the pharmacy as part of a 'Be Cancer Safe' campaign to increase awareness in the Bolsover and North Derbyshire area, and provided training to the pharmacy team as well as carrying out activities for the public. Information on this was also posted on the pharmacy's Facebook page.

The SI was an independent prescriber (IP) and carried out prescribing activities for the pharmacy as well as other pharmacies in the group. He confirmed that he would only prescribe within his area of competence and had shadowed another IP whom was an expert in the field of travel before commencing prescribing in this area. He stated that he had a wide area of competence including asthma and antihypertensives, as he worked in two GP practices and had experience prescribing under the guidance of local GPs.

The pharmacy team were given formal appraisals where performance and development were discussed. These were documented and sent to the HR dept. Day to day issues were discussed as they arose. A dispenser felt there was an open and honest culture in the pharmacy, and she would be comfortable talking to the SI about any concerns she might have. She said the staff could make suggestions or criticisms informally. She felt comfortable admitting and recording errors and explained that it was part of the learning process.

The SI was empowered to exercise his professional judgement and could comply with his own professional and legal obligations. For example, refusing to sell a pharmacy medicine containing codeine, because he felt it was inappropriate. He said the pharmacist manager recently discussed a patient with him who had diabetes and was repeatedly requesting to buy clotrimazole cream, which could indicate the diabetes was not being properly controlled. The pharmacist manager refused the sale and referred the patient to her GP but informed the SI as the patient was not happy with the refusal. The SI stated that there was no pressure to achieve specific targets for services such as Medicines Use Reviews (MUR) but the team were expected to complete them for the benefit of the patients.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises provide a professional environment for people to receive healthcare. The pharmacy has a private consultation room that enables it to provide members of the public with the opportunity to have confidential conversations.

Inspector's evidence

The pharmacy premises including the shop front and facia were clean, well maintained and in a good state of repair. The retail area was free from obstructions, professional in appearance and had a waiting area with three chairs. A cleaning rota was used. The temperature and lighting were adequately controlled. The pharmacy was fitted out to a good standard, and the fixtures and fittings were in good order. Maintenance problems were reported to the SI who arranged for a local contractor to carry out the work, and the response time was appropriate to the nature of the issue.

There was a separate stockroom where compliance aids were stored and this room included a small kitchen area. There was a WC with a wash hand basin, antibacterial hand wash and a hand wash notice. There was a separate dispensary sink for medicines preparation with hot and cold running water. Hand sanitizer gel was available.

The consultation room was uncluttered, clean and professional in appearance. The availability of the room was highlighted by a sign on the door and in the practice leaflet. The pharmacy team used this room when carrying out services such as travel consultations, and when customers needed a private area to talk.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy offers a range of healthcare services which are well managed and easy for people to access. People receive their medicines safely and the pharmacy gives people taking high-risk medicines extra advice. The pharmacy team members are helpful and give healthy living advice and support to people in the community. The pharmacy sources, stores and supplies medicines safely. And it carries out appropriate checks to ensure medicines are in good condition and suitable to supply.

Inspector's evidence

The pharmacy, consultation room and pharmacy counter were accessible to all, including patients with mobility difficulties and wheelchair users. There was a power assisted door at the entrance. The pharmacy had a Facebook page and promoted NHS England public health campaigns such as 'Dry January'. Information on minor ailments was also posted on the page. A list of the services provided by the pharmacy was displayed in the window of the pharmacy along with the opening hours. Services were listed in the practice leaflet and the pharmacy team were clear what services were offered and where to signpost people to a service not offered. There was a small range of healthcare leaflets on display. Signposting and providing healthy living advice were recorded and a note was also made on the patient's medication record (PMR) or as an anonymous counselling note, if the team felt the intervention was significant. For example, a patient reporting she had lost around two stones after being referred to a local weight watchers' group.

The pharmacy offered a travel service which included vaccinations and antimalarials. Private prescriptions which were required for this service were obtained from an IP, who usually worked remotely, following a detailed consultation in the pharmacy. The prescription was sent electronically to the pharmacy if the IP was prescribing remotely. There was a private prescribing SOP for the process. A separate person was required to dispense if the IP happened to be working as the responsible pharmacist and was going to carry out the clinical and accuracy check. The SI said he could discuss clinical decisions with other IPs in the company, if he felt it was necessary. The pharmacy had a private prescribing module from 'PharmOutcomes' which recorded patient consultations, actions and advice. This also included prescribing outcomes and had an automatic GP notification facility, which could be used to inform the patient's usual GP. The SI explained that the automatic notification was not currently used by the pharmacy, but GP notification was printed off and sent to the GP instead. The SI explained that consent was always requested to share information with the patient's GP and most people were happy to provide this. There were individual passwords for PharmOutcomes based on role, so only IPs were able to access the prescribing function. The SI also prescribed for minor ailments which included over-the-counter medicines such as paracetamol and Voltarol, which local GPs had stopped prescribing. The pharmacy offered an ear, nose, throat and eye service under a patient group directive (PGD) which included testing and diagnosis of conditions such as sinusitis, conjunctivitis and ear infections. Antibiotics were supplied in line with local guidelines.

A variety of audits were being carried out. One patient had been counselled on lithium toxicity and the ways to minimise it as a result of a lithium audit. A note of this had been made on his PMR. There was an ongoing audit of patients prescribed non-steroidal anti-inflammatory drugs (NSAIDs). All the patients checked so far were being prescribed gastroprotection where appropriate, so no referrals had been

required. Two patients had been referred for foot or eye checks as part of the diabetes audit. Records of referrals to GPs and interventions were maintained and recorded on the PMR system. Two patients were referred to their GPs for review when it was found that they were being prescribed clopidogrel or ticagrelor for longer than the recommended 12 months following deep vein thrombosis (DVT). These referrals were also noted on the monthly patient safety report.

There was a home delivery service with associated audit trail. Each delivery was recorded, and a signature was obtained from the recipient. A note was left if nobody was available to receive the delivery and the medicine was returned to the pharmacy.

Space was adequate in the dispensary, and the work flow was organised into separate areas with a designated checking area. The dispensary shelves were well organised, neat and tidy. Dispensed by and checked by boxes were initialled on the medication labels to provide an audit trail. Different coloured baskets were used to improve the organisation in the dispensary and prevent prescriptions becoming mixed up. The baskets were stacked to make more bench space available. Stickers were put on assembled prescription bags to indicate when a fridge line or CD was prescribed. 'Speak to Pharmacist' stickers were used to highlight when counselling was required and high-risk medicines such as warfarin and lithium were targeted for extra checks and counselling. INR levels were requested and recorded when dispensing warfarin prescriptions. The team were aware of the valproate pregnancy prevention programme. An audit had been carried out and one patient in the at-risk group had been identified. This patient was counselled about pregnancy prevention and there was a note on her PMR confirming this. The valproate information pack and care cards were available to ensure people in the at-risk group were given the appropriate information and counselling.

Multi-compartment compliance aid packs were supplied to around 50 community patients and around 70 care home patients from two care homes. These were well managed with an audit trail for communications with GPs and changes to medication. A dispensing audit trail was completed, and medicine descriptions were usually included on the packaging to enable identification of the individual medicines. Packaging leaflets were included so patients and their carers could access all the required information about their medicines. Disposable equipment was used. An assessment was made by the pharmacist as to the appropriateness of a compliance pack or if other adjustments might be more appropriate to their needs, before initiating the service.

A dispenser explained what questions to ask when making a medicine sale and when to refer the patient to a pharmacist. She was clear which medicines could be sold in the presence and absence of a pharmacist and understood what action to take if she suspected a customer might be abusing medicines such as a codeine containing product. CDs were stored in a CD cabinet which was securely fixed to the wall. The keys were under the control of the responsible pharmacist during the day and stored securely overnight. Date expired, and patient returned CDs were segregated and stored securely. Patient returned CDs were destroyed using denaturing kits. Pharmacy medicines were stored behind the medicine counter so that sales could be controlled.

Recognised licensed wholesalers were used to obtain medicines and appropriate records were maintained for medicines ordered from 'Specials'. No extemporaneous dispensing was carried out. The pharmacy was compliant with the FMD and the team were scanning medicines to verify and decommission them. Medicines were stored in their original containers at an appropriate temperature. Date checking was carried out and documented. Short dated stock was highlighted. Dates had been added to opened liquids with limited stability. Expired medicines were segregated and placed in designated bins.

Alerts and recalls were received via e-mail messages from head office and from the NHS. These were read and acted on by a member of the pharmacy team. A copy was retained in the pharmacy with a record of the action taken so the team were able to respond to queries and provide assurance that the appropriate action had been taken. A response was also sent to head office.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

Members of the pharmacy team have the equipment and facilities they need for the services they provide. They maintain the equipment so that it is safe and use it in a way that protects privacy.

Inspector's evidence

Current versions of the British National Formulary (BNF) and BNF for children were available and the pharmacist could access the internet for the most up-to-date information. There was a clean medical fridge. The minimum and maximum temperatures were being recorded regularly and had been within range throughout the month. All electrical equipment appeared to be in good working order. There was a selection of clean glass liquid measures with British standard and crown marks. The pharmacy had a range of clean equipment for counting loose tablets and capsules, with a separately marked tablet triangle that was used for cytotoxic drugs. Medicine containers were appropriately capped to prevent contamination.

Computer screens were positioned so that they weren't visible from the public areas of the pharmacy. PMRs were password protected. Individual electronic prescriptions service (EPS) smart cards were used appropriately. Cordless phones were available in the pharmacy, so staff could move to a private area if the phone call warranted privacy.

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.