General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Huncoat Pharmacy, 20 Station Road, Huncoat, ACCRINGTON, Lancashire, BB5 6LS

Pharmacy reference: 1094561

Type of pharmacy: Community

Date of inspection: 26/06/2019

Pharmacy context

This is a community pharmacy in a residential area of Accrington, 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 and the NHS New Medicines Service (NMS). It also supplies medicines in multi-compartmental compliance packs to people living in their own homes and two local care 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 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 try to 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 retail counter. The pharmacist used the bench closest to the retail 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 an SOPs covering dispensing medicines in multi-compartmental compliance packs. 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 finding it easy to find a specific SOP. Some of the SOPs had not been reviewed for several years. For example, the SOP for 'taking in prescriptions' had not been reviewed since August 2011. And so, its contents could be out of date. 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 team member 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 members did not record the reason why the error may have had happened. And so, they may have missed out on some learning opportunities to improve their services. Every month, the pharmacist analysed the near miss log to check for any patterns or common trends. The pharmacist then informally discussed his findings with the team members while they were working. The team members were not able to provide any examples of any steps they had taken to reduce errors. The pharmacist said the dispensing volume was relatively low. And so very few errors occurred. The pharmacy used a similar process to record and report dispensing incidents. These types of incidents were rare. 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 pharmacist had been working at the pharmacy for three months and said he had not had to deal with a dispensing incident in that time.

The pharmacy had a leaflet which advertised how people could make comments, suggestions and complaints. The leaflet was available for people to self-select. 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 record complied with legal requirements.

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.

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.

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 raise professional concerns when necessary.

Inspector's evidence

The pharmacy employed a small team. The regular pharmacist was on duty at the time of the inspection. And was supported by a part-time pharmacy assistant. The pharmacy assistant had started work at the pharmacy five weeks ago. And had been employed to replace another team member who was on long-term absence. A part-time pharmacy assistant and a part-time counter assistant were not present during the inspection. The pharmacist knew many of the people who used the pharmacy and many people were seen addressing him by his first name. And, asking him for advice of various healthcare related topics. The pharmacist said he felt he 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 pharmacist on duty supervised the team member on duty. And she involved the pharmacist in offering advice to people who were purchasing over-the-counter products for various minor ailments. The team member was seen carrying out tasks and managing her workload in a competent manner. And she asked appropriate questions when selling medicines that could only be sold under the supervision of a pharmacist. The team member accurately described the tasks she 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 team member on duty said she had recently asked for training on using the pharmacy's computer systems. The team member had received 1-2-1 support from other team members to help her learn how to create dispensing labels and medicine administration charts.

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 pharmacy supported its team members with a performance appraisal every year. 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. The pharmacist said the team had discussed how to increase the pharmacy's footfall. The team members had sent a proposal to sell confectionary and soft drinks to the pharmacy owners. They said they felt this would improve business and give them more of an opportunity to speak to local people and promote the pharmacy's services. The proposal was approved.

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 secure 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 clean and portrayed a professional image. The benches in the dispensary were slightly cluttered with baskets containing prescriptions and medicines that were waiting to be put away onto the dispensary shelves. But this improved as the inspection progressed. 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 only one seat. The room was smart and professional in appearance. But it was relatively small. 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 generally stores, sources and manages its medicines safely. And it identifies and manages its risks adequately. The team members help people to safely take high-risk medicines. And they have generally managed the risks associated with dispensing medicines in multi-compartmental compliance packs.

Inspector's evidence

There was step-free access into the pharmacy. 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 leaflets covered topics such as cancer, flu and weight loss.

The team members regularly used various stickers during dispensing and they then use these 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 signed the dispensing labels to indicate who had dispensed and checked the medication. And so, a robust audit trail was 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. The pharmacist suggested implementing a system of using a highlighter pen to mark the date on these prescriptions. 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 team attempted to complete the owing the next day.

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 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 identified two people. These people were contacted and given the appropriate advice.

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 retail 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 team members supplied patient information leaflets with the packs each month. The pharmacist visited each care home annually to support them with the management of medicines and discuss ways the pharmacy could improve their service. The pharmacist said he had recently introduced a system to provide the care homes with a separate medicines administration chart for any medicines that were not regularly prescribed to the person, for example short-term antibiotics.

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 three months and it used stickers to highlight short-dated stock. 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 pharmacist said he would discuss with the pharmacy's owners about how the pharmacy could become compliant at their next meeting.

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. The pharmacy obtained medicines from several reputable sources. Drug alerts were received via email to the pharmacy and actioned. And the team kept a record of the action it had taken.

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. Some confidential information was stored in the consultation room. And so, there was a risk that members of the public could see this information. The computers were password protected. Cordless phones assisted 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.