General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Hyde Pharmacy, Thornley Street, HYDE, Cheshire, SK14 1JY

Pharmacy reference: 1099027

Type of pharmacy: Community

Date of inspection: 09/03/2020

Pharmacy context

This is a busy community pharmacy next to a medical centre in a residential area on the edge of the town. Most people who use the pharmacy are from the local area. The pharmacy dispenses mainly NHS prescriptions and sells a range of over-the-counter medicines. The pharmacy stays open for 100 hours per week and is open late into the evening.

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 adequately manages risks. Pharmacy team members take steps to improve patient safety, and the pharmacists complete training so they know how to protect children and vulnerable adults. The team keeps people's private information safe. But some team members have not completed training on data protection, so they might not fully understand their role in this. The team generally keep the records required by law, but some details are missing, which could make it harder to understand what has happened if queries arise.

Inspector's evidence

There were up-to-date Standard Operating Procedures (SOPs) for the services which had been read and signed by most members of the pharmacy team. They had been recently reviewed. One of the medicine counter assistants (MCA) had not yet signed some of the SOPs relevant to her role such as the ‘support for self-care’ SOP and the 'sales of medicines protocol', which covered healthy living, signposting and over-the-counter (OTC) medicines. She confirmed her understanding of the procedures and said she would read and sign the SOPs as soon as she could. Members of the team were generally carrying out duties in line with their level of training. Most of the staff did not wear a uniform or anything to indicate their role, which meant people might be unclear what their role and level of qualification was. The name of the responsible pharmacist (RP) was displayed in line with RP regulations.

There was a SOP which explained what actions to take in the event of a near miss or dispensing error. Near misses were recorded on a tally chart to help detect trends and the details were recorded in a book, where there was a section to record the actions which had been taken to avoid re-occurrences. Elastic bands had been put on medicines which had similar packaging such as levothyroxine 75ug which was very similar to levothyroxine 100ug, and phenobarbital 60mg which was in almost identical packaging to phenobarbital 30mg. Team members confirmed that they discussed near misses and errors within the pharmacy team and said the pharmacist superintendent (SI) reviewed them every three or four months. The RP said he would follow the SOP if an error was brought to his attention and he would also make the other regular pharmacist and the SI aware of it.

There was a ‘dealing with complaints’ SOP. The complaints procedure and how to give feedback was outlined in practice leaflets which were on display. A customer satisfaction survey was taking place. Results from the April 2018- March 2019 survey was available on the www.NHS.uk. website. An area of strength was ‘service received from the pharmacist’. An area identified which required improvement was ‘providing advice on physical exercise’. There was no published response to this.

Insurance arrangements were in place. The RP record was generally in order, although the time which the RP ceased his duties had not been entered on some of the days. Private prescription records were maintained electronically. The prescriber's details were missing on one of the samples checked, so it did not provide an accurate audit trail. There were some loose pages in the controlled drug (CD) register and they were not numbered. This was not in line with CD requirements and compromised the accuracy of the register. The RP said that he had requested replacement pages in the form of bound books, but until they arrived, he was recording the running balance at the top of each new page, so it would be evident if a page did go missing. Three CD balances were checked and found to be correct. The running

balance was usually checked when CDs were supplied, and the RP had carried out some random spot checks on CDs which were not dispensed very often.

Team members had a basic understanding about information governance (IG) but could not locate any written IG policies, procedures or confidentiality agreements. They could not recall if they had been trained on the general Data Protection Regulation (GDPR), apart from the RP who had received training whilst working in another pharmacy. A dispenser described the process for dealing with confidential waste, which was collecting it in a designated place and then shredding it at the end of the day. The RP confirmed this procedure was being followed.

The RP had completed the Centre for Pharmacy Postgraduate Education (CPPE) level 2 training on safeguarding children and vulnerable adults. Another member of the team said he would report any concerns to the pharmacist but he had not received any formal training on safeguarding, so he might not always know what signs to look for. He said they did not have a written chaperone policy, but a female member of staff would always accompany a person having a private conversation with the pharmacist, if they requested it. Members of the pharmacy team had completed training on dementia so had an understanding of people living with this condition. Some of the team were wearing 'Dementia Friends' badges to highlight this to people.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy team members generally have the right qualifications for the jobs they do and they work well together. They are comfortable providing feedback to the pharmacists and they receive feedback about their own performance. However, ongoing training is not structured and it does not happen regularly, so they might not always identify gaps in their knowledge.

Inspector's evidence

There was a regular locum pharmacist (RP), two NVQ2 qualified dispensers (or equivalent) and two MCAs on duty at the time of the inspection. The staff level was adequate for the volume of work during the inspection and the team were observed working collaboratively with each other and the patients. Absences were covered by re-arranging the staff rota. Some members of the team were part-time so there was flexibility to cover absences.

The RP worked two or three days a week in the pharmacy and another regular locum pharmacist worked the other days. The SI worked in the pharmacy every two or three months but telephoned the pharmacy at least weekly to update them on any issues. The SI was in regular contact with the two pharmacists and the RP said he passed on any relevant messages to the rest of the team.

The duties of the MCAs included occasionally putting medicines away in the dispensary, but neither of them were enrolled onto accredited dispensing assistant courses. This was not in line with GPhC minimum training requirements. The RP made a note to discuss the possibility of the MCAs completing at least one module from the dispensing assistant course, to enable them to perform this duty if they weren't going to be enrolled onto the full course. One of the MCAs had read the 'Deliveries-receipt, checking and putting away' SOP but the other one had not, so they might not be clear about the procedure.

There was no record of any structured ongoing training once accredited qualification courses had been completed, and the pharmacy team members did not have regular protected training time. There were no formal discussions with team members about their performance and development, but issues were discussed informally with the SI when he worked in the pharmacy. A dispenser said he would feel comfortable talking to the pharmacists or the SI about any concerns he might have and he thought there was an open and honest environment.

The RP said he felt 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 he was encouraged to carry out Medicines Use Reviews (MURs) and flu vaccinations during the season, but there were no set targets and he didn't feel under any pressure to carry them out.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises provide a professional environment for people to receive healthcare services. 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 and in an adequate state of repair. The retail area was free from obstructions, professional in appearance and had a waiting area with some bench seating. The floor had just been mopped and the pharmacy smelt of disinfectant. Several customers commented about the clean smell and welcomed the focus on cleanliness, in light of the Corona virus outbreak in the UK. The temperature and lighting were adequately controlled. Maintenance problems were reported to the SI who would contact the owners of the building if necessary.

Staff facilities included a kitchen area and a WC with a wash hand basin and antibacterial hand wash. There was a separate dispensary sink for medicines preparation with hot and cold running water. The consultation room was equipped with a sink, and it was uncluttered, clean and professional in appearance. The availability of the room was highlighted by a sign on the door. The room was used when carrying out some services such as MURs and when customers needed a private area to talk.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's services are available over extended hours so they are easy for people to access. The pharmacy gets its medicines from licensed suppliers and it carries out some checks to ensure medicines are in good condition and suitable to supply. Services are generally well managed, but the lack of clear audit trails when assembling and checking compliance aid packs, and when delivering medicines to people's homes, may make it harder for the team to deal with any queries or problems that arise.

Inspector's evidence

The pharmacy, consultation room and pharmacy counter were accessible to all, including patients with mobility difficulties and wheelchair users. There was an automatic door. Some of the services provided by the pharmacy were advertised in the window of the pharmacy with the opening hours, and services were also listed in the practice leaflet. There was a large range of healthcare leaflets. For example, posters and leaflets on bowel cancer screening, Flu, men's health and support for domestic abuse. The pharmacy team were clear what services were offered and where to signpost to a service not offered. Signposting and providing healthy living advice were not recorded. It was therefore difficult to monitor the effectiveness of the health promotional activities. Part of the pharmacy team were multilingual speaking Bengali, Hindi, and Urdu, which assisted some of the non-English speakers in the community.

The pharmacy offered a repeat prescription ordering service and an MCA confirmed that all patients were contacted before their prescriptions were ordered, to check their requirements. This was to reduce stockpiling and medicine wastage. There was a delivery service but there were no records of what was delivered, and signatures were not obtained from the recipient to confirm safe receipt, unless the medication was a CD. The delivery SOP could not be located, but team members confirmed that there was one and the delivery driver had read it.

Space was limited in the dispensary, but the work flow was organised into separate areas with a designated checking area. The benches and dispensary shelves were neat, tidy and clean. Dispensed by and checked by boxes were generally 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. Laminated notes were put on assembled prescription bags to indicate when a fridge line or CD was prescribed. The RP said a note was written on the prescription if he wished to counsel the patient or make any extra checks. He said he checked people had a blood test within the previous three months when he supplied lithium. INR levels were requested but not normally recorded when dispensing warfarin prescriptions. The RP was aware of the valproate pregnancy prevention programme. He said he did not believe any of the regular patients were in the at-risk group. He was not able to locate the valproate information pack and care cards but said everyone received their medication in original packs and all of them now contained the care card within the packaging. The RP had counselled around seven or eight people on the signs of toxicity and checked that they understood what to do in the event of a missed dose as part of a methotrexate audit.

There was a new SOP for the assembly of compliance aid packs and the team were following the SOP.

The packs were assembled from the patients record sheet which was based on their usual prescription and then labelled from the actual prescription when it was received, prior to supply. The packs were labelled with the patient's name and address only until the prescription was received, which could be up-to a week later, so they did not contain the names of the medication until they were ready to be supplied. This breached labelling regulations and might increase the risk of error. The SI had considered this risk necessary because the medical practice refused to send the prescriptions to the pharmacy until the day they were due to be supplied, which did not leave the pharmacy team enough time to assemble and check the compliance packs. The SI felt that if the pharmacy did not assemble the packs in advance, the team would have to rush and this would compromise patient safety, and there was a chance that people might go without their medication, if something was out-of-stock. So, he had clearly outlined this process in the new SOP.

The RP said he accuracy checked against the patients record sheet and then an additional check was completed by a pharmacist when the prescription was received, before the packs were supplied. However, there was only a partial dispensing audit trail on the packs, and it was not clear who had dispensed, accuracy and clinically checked each pack. So, it was not always evident that these checks had taken place and it might not be possible to identify who was responsible for any incident or error, limiting what could be learned from things that go wrong. There was only a partial audit trail for changes to medication in multi-compartment devices, so It was not always clear who had confirmed the changes and the date the changes had been made, which could cause confusion when assembling packs. Medicine identification was not completed to enable identification of the individual medicines and packaging leaflets were not included, unless the patient was having the medication for the first time, despite this being a mandatory requirement. This could mean patients and carers might not have easy access to information they need. There was a SOP for people with disabilities which described an assessment to be undertaken by people requesting their medicines in compliance aid packs. The RP said anyone requesting a compliance pack were asked to contact their GP or the medicines manager at the practice because referrals for compliance packs had to come from their GP practice, following an assessment by them.

An MCA explained what questions she asked when making a medicine sale and knew when to refer to a pharmacist. She was clear which medicines could be sold in the presence and absence of a pharmacist and was clear 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 CD keys were under the control of the responsible pharmacist during the day and stored securely overnight . Date expired CDs were segregated and stored securely. There was a denaturing kit available for the destruction of CDs. Pharmacy medicines were stored behind the medicine counter so that sales could be controlled.

Recognised licensed wholesalers were used for the supply of medicines and appropriate records were maintained for medicines ordered from 'Specials'. No extemporaneous dispensing was carried out. The pharmacy was not compliant with the Falsified Medicines Directive (FMD) but the pharmacy had the required equipment to allow scanning of medicines to verify or decommission them. There was a SOP covering FMD, although none of the team had signed to indicate they had read it, and they said they were still waiting for training and the go ahead from the SI.

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. Alerts and recalls were received via email from PharmData. The RP said these were read and acted on by a member of the pharmacy team. He thought they were retained but he could not locate the file, and so he could not provide assurance

that the appropriate action had always been taken. The team could recollect the last two recalls they had received, and what action they had taken, from memory.

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 British National Formulary (BNF) and BNF for children were available and the team could access the internet for the most up-to-date information. The RP said he used an App on his mobile phone to access the electronic BNF.

There was a large medical fridge. The minimum and maximum temperatures were being recorded daily and had been in range throughout the month. There was a selection of clean glass liquid measures with British standard and crown marks. Separate measures were marked and used for methadone solution. A small plastic measure was in use which did not have an accuracy stamped, so there was a risk that this might not be accurate and was less easy to clean. The pharmacy had a small range of equipment for counting loose tablets and capsules, with a separately marked tablet triangle that was used for cytotoxic drugs. Computer screens were positioned so that they weren't visible from the public areas of the pharmacy. Patient medication records (PMRs) were password protected. 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.