General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: HBS Pharmacy, St. Fillans Medical Centre, 2 Liverpool Road, Penwortham, PRESTON, Lancashire, PR1 0AD

Pharmacy reference: 1103445

Type of pharmacy: Community

Date of inspection: 23/04/2019

Pharmacy context

This is a community pharmacy inside a medical centre. It is situated in the residential area of Penwortham, south-west of Preston city centre. The pharmacy dispenses NHS prescriptions, private prescriptions and sells over the counter medicines. It also provides a range of services such as seasonal flu vaccinations, a minor ailment service and emergency hormonal contraception. A number of people receive their medicines inside multi-compartment compliance aids.

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	1.5	Standard not met	The pharmacy's indemnity insurance arrangements do not provide sufficient cover for the pharmacy services.
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 not all met**

Summary findings

The pharmacy team follows written procedures to help make sure the pharmacy provides services safely and effectively. Members of the team record their mistakes so that they can learn from them, but the records are not formally reviewed so some learning opportunities may be missed. The pharmacy has professional indemnity insurance, but it does not provide enough cover for all of the pharmacy services. People who work in the pharmacy are given training about the safe handling and storage of data. This helps to make sure that they know how to keep private information safe.

Inspector's evidence

There was a set of standard operating procedures (SOPs) which were last reviewed in November 2018. The pharmacy team had signed to say they had read and accepted the SOPs.

Dispensing errors were recorded electronically and submitted to the superintendent (SI). The most recent error was a picking error between finasteride 5mg and felodipine 5mg tablets. The pharmacist investigated the error and recorded it on the NRLS system. Actions taken to reduce the risk of similar errors included making the pharmacy team aware and separating the dispensary locations of these medicines.

The pharmacist would highlight near miss errors to members of the pharmacy team at the point of an accuracy check and they were asked to record their own errors on a paper log. He said at the end of the month he would discuss errors with staff but there was no formal review. The discussion included identifying common patterns or underlying factors. Actions taken in response to near misses included placing a 'check strength' sticker in various dispensary locations of medicines that have a number of different strengths.

Roles and responsibilities of the pharmacy team were described in individual SOPs. The trainee dispenser was able to describe what their responsibilities were. A dispenser was clear about the tasks which could or could not be conducted during the absence of a pharmacist. Staff did not have a standard uniform or badges to identify their name and role. So people may not be clear about what role the member of the pharmacy team plays. The responsible pharmacist (RP) had their notice displayed prominently.

The pharmacy had a complaints procedure and it was displayed in the retail area. It advised people how to make direct contact with the pharmacist. Complaints were recorded on a standardised form to be followed up by the SI or manager.

A certificate of professional indemnity insurance was supplied by the company following the inspection. However; the limit of cover was £100,000 for 'dispensing errors' and it was not clear if this covered all of the registerable activities conducted by all members of the pharmacy team.

Records for the RP, private prescriptions, and emergency supplies appeared to be in order. Controlled drugs (CDs) registers were maintained electronically with running balances recorded and checked every two weeks. The balance of two random CDs were checked and found to be accurate. The balance of a

third CD was found to have a deficit, but this was promptly identified by the pharmacist as a missed recorded entry and rectified. Patient returned CDs were recorded in a separate register.

Records of unlicensed specials did not always contain the required information about the date of supply and to whom the supply was made. This information is necessary to provide an audit trail in the event of a concern about the medicine.

An information governance (IG) policy was available in a folder. The pharmacy team had read and signed the policies in the folder. Staff had signed confidentiality agreements in their contracts. When questioned, the dispenser was able to correctly describe how information was segregated until it was shredded using the on-site shredder. Passwords to websites containing patient-sensitive data were on display in the dispensary; which is not in line with current IG guidance. A poster in the retail area gave information about how the pharmacy handled patient data.

Safeguarding procedures were included in the SOPs which were used to form training for the pharmacy team. The pharmacist said he had completed the CPPE safeguarding training. Contact details of the local safeguarding board were on display within the dispensary. The dispenser said she would initially report any concerns to the pharmacist on duty.

Principle 2 - Staffing ✔ Standards met

Summary findings

There are enough staff to manage the pharmacy's workload and they are properly trained for the jobs they do. The company provides members the pharmacy team with learning modules to complete to help them keep their knowledge up to date. But there is no structure for this. So their learning needs may not always be met.

Inspector's evidence

The pharmacy team included a pharmacist – who was the superintendent, a pharmacy manager – who was not dispenser trained, a pharmacy technician, four dispensers and a new employee – who was due to be placed onto a training course. The pharmacy team were adequately trained or in accredited training programmes. The pharmacy manager was not involved with handling or the supply of medicines.

The normal staffing level varied due to the pharmacy's prolonged opening hours. Staff worked to a rota so that there was always another member of staff present to support the pharmacist, and during the core hours of 8am to 8pm there were at least two other staff.

The volume of work appeared to be managed. Staffing levels were maintained by a staggered holiday system.

A work-placement student was present who was shadowing the pharmacy technician on the counter. He had read the SOPs but his roles were limited to till operation; with counter sales and handout of medicines completed by the pharmacy technician.

The new employee had commenced her role within the last seven days and had read and signed the SOPs as part of her induction. She was clear about her roles and her limitations as a trainee dispenser, with all of her work being currently overseen by other members of the pharmacy team.

The company provided the pharmacy team with some additional learning such as dementia friends and healthy living pharmacy modules. These appeared relevant to the services provided and those completing the learning. But training was not provided in a structured and/or consistent manner.

The dispenser gave an example of how he would sell a pharmacy only medicine using the WWHAM questioning technique and refer to the pharmacist if needed.

The superintendent pharmacist said he felt able to exercise his professional judgement and this was respected by the pharmacy manager and directors of the company.

A dispenser had commenced her employment about 12 months ago and she said she received a good level of support from the pharmacy team and was able to ask for help if she needed it.

Appraisals were conducted by the pharmacy manager. A dispenser said the manager discussed her performance, training requirements and areas for improvement. She felt that the appraisal process was a good chance to have an open conversation about her work.

Staff were aware of the whistleblowing policy in place and said that they would be comfortable to escalate any concerns to the manager or SI.

There were no performance targets set in relation to pharmacy services.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are suitable for the services provided. A consultation room is available to allow private conversations.

Inspector's evidence

The pharmacy was generally clean and tidy and appeared adequately maintained. The temperature was controlled in the pharmacy by the use of a thermostatic air conditioning unit. Lighting was sufficient.

The dispensary was small, but the workload was managed to make best use of the space e.g. by completing tasks such as assembly of compliance aids during quieter weekend periods. A sink and washing facilities were available within the dispensary. Customers were not able to view any patient sensitive information due to the position of the dispensary and access was restricted by the position of the counter. The staff had access to a kettle and WC facilities.

A consultation room was available. There was a computer, a desk, seating, adequate lighting, and a wash basin. The patient entrance to the consultation room was clearly signposted and indicated if the room was engaged or available. The consultation room was cluttered with boxes and staff belongings. This does not portray the professional appearance expected of a consultation room. A chaperone policy was displayed inside the room.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's services are accessible to most people. And they are suitably managed to help make sure that they are provided safely. The pharmacy gets its medicines from reputable sources, manages them safely and carries out regular checks to help make sure that all its medicines are in good condition.

Inspector's evidence

Access to the pharmacy was via an automatic door and was suitable for wheelchair users. The consultation room was wheelchair friendly and the PMR system was capable of producing large print font.

Pharmacy practice leaflets gave information about the services offered. Pharmacy staff were able to list and explain the services provided by the pharmacy. The pharmacy opening hours were displayed as part of their practice leaflet. A range of leaflets provided information about various healthcare topics. There were local restrictions in the area which prevented the pharmacy from routinely ordering prescriptions on behalf of the patient.

The pharmacy had a delivery service. Deliveries were segregated after their accuracy check and a delivery sheet was used to obtain patient signatures on receipt of the medication. Unsuccessful deliveries would be returned to the pharmacy and a card posted through the letterbox indicating the pharmacy had attempted a delivery. Some deliveries were posted through the letterbox or delivered to an alternative address following patient consent. A verbal risk assessment was completed but there was no review of this. So the pharmacy cannot provide assurance that the arrangement continues to be suitable for the patient. CDs were recorded on a separate delivery sheet for individual patients and a separate signature obtained on receipt of delivery.

For multi-compartment compliance aid patients; a record sheet contained details of currently blistered medication and any external items. Medication changes were confirmed with the GP surgery before being recorded on the patient’s PMR and the record sheet was amended. Details of who made the change and when were recorded in a medication log on the reverse of the record. Hospital discharge sheets were sought and previous records were retained for future reference.

Disposable equipment was used to provide the service and the compliance aids included a dispensing check audit trail. Medication descriptions and patient information leaflets (PILs) were not routinely supplied to patients. Therefore, people may not have full access to information they require to make decisions about their medicines and to take them safely.

Dispensed by and checked by boxes were initialled on medication labels to provide an audit trail. Dispensing baskets were used for segregating individual patient prescriptions to avoid items being mixed up and the baskets were colour coded to help prioritise dispensing. Owing slips were in use to provide an audit trail if the full quantity could not be immediately supplied.

Dispensed medicines awaiting collection were segregated away from the dispensing area on a collection shelf using an alphabetical retrieval system. Prescriptions were retained and stickers were used to clearly identify when fridge or CD safe storage items needed to be added. Upon handout staff were

seen to confirm the patient's name and address.

When an insulin was handed over to a patient, the pharmacy technician said he would show the patient their insulin to ensure it was correct.

Schedule 3 and 4 CDs stored on collection shelves were usually highlighted to indicate their presence so that staff could check prescription validity at the time of supply. However; there were some prescriptions for gabapentin which were found not highlighted as such. This indicates there may be some gaps in this process.

High risk medicines (such as warfarin, lithium and methotrexate) were not routinely highlighted. So the pharmacy team may not be aware when they are being handed out in order to check that the supply is suitable for the patient.

The staff were aware of the risks associated with the use of valproate in pregnancy and educational materials were available to hand out. The pharmacist said he had spoken to all people who may become pregnant and established the supply was safe. This was recorded on the patient's PMR.

The pharmacy was not yet able to meet the safety features of the Falsified Medicines Directive (FMD). The equipment to implement the scanning requirements was present in the pharmacy but they were awaiting installation of software from their PMR supplier. Therefore the pharmacy was not currently compliant with the legislation.

Stock was generally date checked on a monthly basis. A date checking matrix was signed by staff and shelving was cleaned as part of the process. Short-dated stock was highlighted using a sticker and liquid medication had the date of opening written on.

Controlled drugs were stored appropriately in the CD cabinet, with clear segregation between current stock, patient returns and out-of-date stock.

There was a clean medicines fridge with a minimum and maximum thermometer. The minimum and maximum temperature was being recorded daily and records showed it had been in range.

Patient returned medication was segregated from current stock in designated bins for storing waste medicines located away from the dispensary.

Drug alerts were received electronically by electronic software. This also recorded the action taken, when and by whom.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy team has access to the equipment they need for the services they provide.

Inspector's evidence

The staff had access to the internet for general information. This included access to medicine information on the BNF, BNFc and drug tariff resources. All electrical equipment appeared to be in working order. According to the stickers attached, all electrical equipment had been PAT tested in May 2015.

There was a selection of liquid measures, some with British Standard and Crown marks. There was also a non-standardised plastic measure in use which does not provide the same assurance of accuracy. Separate measures were designated and used for methadone. The pharmacy also had counting triangles for counting loose tablets including a designated tablet triangle for cytotoxic medication

Computers were password protected and screens were positioned so that they weren't visible from the public areas of the pharmacy. A cordless phone was available in the pharmacy which allowed the staff to move to a private area if the phone call warranted privacy.

The consultation room was used appropriately; patients were offered its use when requesting advice or when counselling was required. Substance misuse clients were directed to the use of the consultation room to provide 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.