General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: HBS Pharmacy, 30 St. Marys Road, Bamber Bridge, PRESTON, Lancashire, PR5 6TD

Pharmacy reference: 1103968

Type of pharmacy: Community

Date of inspection: 09/12/2019

Pharmacy context

This is a community pharmacy located inside a purpose-built unit, in the grounds of a medical centre. It is situated in the residential area of Bamber Bridge, south of Preston city centre. The pharmacy dispenses NHS prescriptions, private prescriptions and sells over-the-counter medicines. It also provides a range of services including seasonal flu vaccinations, a minor ailment service and emergency hormonal contraception. The pharmacy supplies medicines in multi-compartment compliance aids for some people to help them take the medicines at the right time.

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 team follows written procedures, and this helps to maintain the safety and effectiveness of the pharmacy's services. The pharmacy keeps the records it needs to by law. And members of the team are given training so that they know how to keep private information safe. They discuss things that go wrong to help identify learning. But they do not always keep records of things that go wrong, so some learning opportunities may be missed.

Inspector's evidence

There was a current set of standard operating procedures (SOPs) which had been issued in March 2017. Members of the pharmacy team had signed to say they had read and accepted the SOPs.

Dispensing errors were recorded on a standardised form. The most recent error involved the incorrect supply of ropinirole instead of risperidone tablets. The pharmacist had investigated the error and discussed his findings with the pharmacy team. Action had been taken to help reduce the risk of further errors by moving the two medicines away from each other. A blank paper log was available to record near miss incidents. Members of the pharmacy team said they would record near miss incidents and send the paperwork to their head office at the end of the month for analysis. But previous records of near miss incidents or their analysis were not kept at the pharmacy. So learning opportunities may be missed. The pharmacist explained that he would discuss near miss incidents with the pharmacy team when he discovered them. He gave examples of action which had been taken to help prevent mistakes being repeated. For example, using stickers to highlight different formulations of carbamazepine and esomeprazole to prevent common picking errors.

Roles and responsibilities of the pharmacy team were described in individual SOPs. The dispenser was able to explain what his responsibilities were and was clear about the tasks which could or could not be conducted during the absence of a pharmacist. The responsible pharmacist (RP) had their notice displayed prominently. The pharmacy had a complaints procedure. A notice in the retail area advised people they could discuss any concerns or feedback with the pharmacy team. Any complaints would be recorded and followed up by the pharmacy team or head office. A current certificate of professional indemnity insurance was seen.

Records for the RP, private prescriptions, emergency supplies and unlicensed specials appeared to be in order. Controlled drugs (CDs) registers were maintained with running balances recorded and checked weekly. Two random balances were checked, and both found to be accurate. A register to record patient returned CDs was available.

Information governance (IG) procedures were in place. All members of the pharmacy team had completed IG training and signed confidentiality agreements. A dispenser was able to describe how confidential waste was segregated to be removed by a waste carrier. A privacy notice was on display and explained how people's data was handled and stored by the pharmacy.

Safeguarding procedures were included in the SOPs. The pharmacy team received in-house safeguarding training and the pharmacist said he had completed level 3 safeguarding training. Contact details of the local safeguarding board were on display in the dispensary. A dispenser said he 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 appropriately trained for the jobs they do. Members of the pharmacy team complete some additional training to help them keep their knowledge up to date.

Inspector's evidence

The pharmacy team included a pharmacist manager, a pharmacy technician, a dispenser and a pharmacy student. Members of the pharmacy team had completed the necessary training for their roles. The normal staffing level during the core hours between 9am and 5pm was a pharmacist and three other staff. A counter assistant had recently left and the pharmacy was in the process of recruiting a new member of staff. The volume of work appeared to be managed. There was a staggered holiday system in place and relief staff from other branches could be requested if needed.

Members of the pharmacy team completed some additional training, for example they had recently completed a training topic about children's oral health. But further training was not provided in a structured or consistent manner. So learning needs may not always be fully addressed.

The dispenser gave examples of how he would sell a pharmacy only medicine using the WWHAM questioning technique, refuse co-codamol sales he felt were inappropriate and refer people to the pharmacist if needed. The pharmacist said he felt able to exercise his professional judgement and this was respected by the pharmacy team and the head office. The dispenser said he felt a good level of support from the pharmacist and felt able to ask for further help if he needed it. Appraisals were conducted by the pharmacist manager. The dispenser said he felt that the appraisal process was a good chance to receive feedback and he felt able to speak about any of his own concerns. Staff were aware of the whistleblowing policy and said that they would be comfortable reporting any concerns to the manager or SI. There were targets set for MURs and NMS. The pharmacist said he did not feel under pressure to achieve these.

Principle 3 - Premises ✔ Standards met

Summary findings

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

Inspector's evidence

The pharmacy was generally clean and tidy, and appeared adequately maintained. The size of the dispensary was sufficient for the workload and access to it was restricted by the position of the counter. A sink was available within the dispensary. Customers were not able to view any patient sensitive information due to the position of the dispensary. The temperature was controlled by the use of air conditioning units. Lighting was sufficient. The staff had access to a kitchenette area and WC facilities.

A consultation room was available with access restricted by use of a lock. The space was clutter free with a computer, desk, seating, adequate lighting, and a wash basin. The patient entrance to the consultation room was clearly signposted.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's services are easy to access. And it manages and provides them safely. It gets its medicines from recognised sources, stores them appropriately and carries out some checks to help make sure that they are in good condition.

Inspector's evidence

Access to the pharmacy was level via an automatic door and was suitable for wheelchair users. There was also wheelchair access to the consultation room. Pharmacy practice leaflets gave information about the services offered and information was also available on the website. Pharmacy staff were able to list and explain the services provided by the pharmacy. If the pharmacy did not provide a particular service staff were able to refer patients elsewhere using a signposting folder. The pharmacy opening hours were displayed and a range of leaflets provided information about various healthcare topics.

The pharmacy had a delivery service. Deliveries were segregated after their accuracy check and a delivery sheet was used to obtain signatures from the recipient to confirm delivery. Unsuccessful deliveries would be returned to the pharmacy and a card posted through the letterbox indicating the pharmacy had attempted a delivery. Some people had alternative delivery arrangements, such as leaving the delivery in the porch or with a neighbour. The pharmacist said this was a one-off arrangement, and a verbal risk assessment was completed each time, but this was not recorded. So the pharmacy may not be able to always show it had considered all of the risks when medicines were left in this way. CDs were recorded on a separate delivery sheet for individual patients and a signature was obtained to confirm receipt.

The pharmacy team initialled dispensed by and checked by boxes on dispensing labels to provide an audit trail. They used dispensing baskets to separate individual patients' prescriptions to avoid items being mixed up. 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 kept on a collection shelf using a numerical retrieval system. Prescription forms were retained, and stickers were used to clearly identify when fridge or CD safe storage items needed to be added. Staff were seen to confirm the patient's name and address when medicines were handed out.

Schedule 3 and 4 CDs were highlighted so that staff could check prescription validity at the time of supply. The pharmacist said he would also highlight high-risk medicines (such as warfarin, lithium and methotrexate) and counsel patients to check their latest blood test results. The staff were aware of the risks associated with the use of valproate during pregnancy. Educational material was available to hand out when the medicines were supplied. The pharmacist said he had completed an audit and would speak to any patients who were at risk to make them aware of the pregnancy prevention programme, which would be recorded on their PMR. The pharmacy team said they were not aware of any current patients who met the risk criteria.

Some medicines were dispensed in multi-compartment compliance aids. Before a person was started on a compliance aid the pharmacist would complete a verbal assessment about their suitability, but this was not recorded. A record sheet was kept for each patient, containing details of their current medication. Any medication changes were confirmed with the GP surgery before the record sheet was

amended. 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 were labelled with medication descriptions and a dispensing check audit trail. Patient information leaflets (PILs) were routinely supplied.

The pharmacy provided a flu vaccination service using a patient group directive (PGD). A current PGD was available to view and the pharmacist confirmed he had the necessary training to provide the service. Records of vaccinations were kept and the patient's GP surgery was informed that they had been vaccinated.

Medicines were obtained from licensed wholesalers, and any unlicensed medicines were sourced from a specials manufacturer. The pharmacy was not yet meeting the safety features of the falsified medicine directive (FMD), which is now a legal requirement. Equipment was installed but the pharmacy team had yet to commence routine checks of medicines. Expiry dates of stock were checked on a monthly basis. A date checking matrix was signed by staff as a record of what had been checked. Short dated stock was marked with an ‘S’ and liquid medication generally had the date of opening written on. But Combivent and aripipazole were found out of date. This indicated there may be some gaps in this process. The pharmacist said he would ask the pharmacy team to recheck the stock. This indicates there may be some gaps in this process. The pharmacist said he would ask the pharmacy team to recheck the stock.

Controlled drugs were stored appropriately in the CD cabinet, with clear segregation between current stock, patient returns and out of date stock. CD denaturing kits were available for use. There was a clean medicines fridge with a thermometer. The minimum and maximum temperature was being recorded daily and records showed they had been within the required range for the last 3 months. Patient returned medication was disposed of in designated bins located away from the dispensary. Drug alerts were received by email from the MHRA. Alerts were printed, action taken was written on, initialled and signed before being filed in a folder.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

Members of the pharmacy team have access to the equipment they need for the services they provide. And they maintain the equipment so that it is safe to use.

Inspector's evidence

The staff had access to the internet for general information. This included access to the BNF, BNFc and drug tariff resources. All electrical equipment appeared to be in working order. There were no stickers attached to indicate they had been PAT tested. There was a selection of liquid measures with British Standard and Crown marks. 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. Equipment was kept clean.

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.