General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: www. ukpharmacylive .com/co.uk, 150 Deane Road, BOLTON, Lancashire, BL3 5DL

Pharmacy reference: 1104286

Type of pharmacy: Closed

Date of inspection: 22/08/2022

Pharmacy context

This pharmacy is located on a main road close to the town centre. People cannot visit the pharmacy in person. The pharmacy dispenses NHS prescriptions. It supplies a large number of care homes and most medicines are supplied in multi-compartment compliance aid packs to help people take their medicines at the right time. The pharmacy has a website which provides information about the pharmacy and its services.

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	1.1	Standard not met	The pharmacy team members do not always follow the pharmacy's Standard operating procedures.
		1.7	Standard not met	The pharmacy team are not properly trained about how to deal with confidential information and this risks breaching people's confidentiality.
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 not all met	4.3	Standard not met	Medicines returned from care home are not dealt with appropriately. The pharmacy does not always store CD medicines securely and in line with safe custody regulations. The pharmacy cannot provide assurance that the temperature of the medical fridge is appropriately monitored.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance **Standards not all met**

Summary findings

The pharmacy takes some action to manage risks and improve patient safety. But some members of the pharmacy team do not have a clear understanding of the pharmacy's operating procedures. So, they may fail to work effectively and not understand their role in keeping people's private information safe and protecting the welfare of vulnerable people. The pharmacy generally completes the records that it needs to by law but some of the records are incomplete or inaccurate, which could cause confusion and makes audit more difficult.

Inspector's evidence

The pharmacy had standard operating procedures (SOPs) for the services it provided. The SOPs contained signatures showing that some members of the pharmacy team had read and accepted them. But there was nothing to indicate that newer members of the team had read them, so there was a risk that they might not fully understand what was expected of them. And some SOPs were not being followed. For example, the disposal of patient-returned CDs SOP. There was more than one version of some of the SOPs, for example, the delivery SOP. This was confusing and could cause misunderstanding of the correct procedure to follow. And there was no record to show whether either of the delivery drivers had read the SOP. Roles and responsibilities were set out in SOPs and the pharmacy team members were performing duties which were in line with their roles. The name of the responsible pharmacist (RP) was appropriately displayed.

The pharmacy team recorded dispensing incidents and the actions taken to prevent a re-occurrence. For example, when similar packaging had been separated. A copy of the report was printed out and filed for reference. Team members reported near misses on a log and discussed them within the team. Reviews and discussions were not usually recorded, so some team members might miss out on learning opportunities.

The pharmacy manager explained that complaints were rare, but they would be referred to him to deal with. He said care home staff knew to contact him directly and the pharmacy's contact details and a link to report complaints were on the pharmacy's website. A current certificate of professional indemnity insurance was on display in the pharmacy. Private prescriptions and emergency supply records were recorded electronically. Some private prescriptions were also recorded in a book. This was not consistently used, and it was not clear which was the official record, which might cause confusion in the event of a problem or query. Three private prescriptions which had been recorded in the electronic register could not be located, and the pharmacy manager thought these might not have actually been supplied. The RP record and the controlled drug (CD) register were generally in order. Records of CD running balances were kept and there were some documented audits. Three CD balances were checked and found to be correct. Patient returned CDs from care homes were not recorded when returned to the pharmacy, which was not in line with the SOPs.

There were information governance (IG) SOPs, but some of the staff had not read them. Team members could not remember if they had completed any training about confidentiality and data protection. And there was no record to show this. A member of the public, asking about the whereabouts of a doctor,

was allowed entry into the dispensary by one of the newer members of staff. This risked breaching patient confidentiality, as well as being a security risk. He was immediately told to leave by the RP, when she noticed this. The member of staff said she had mistaken him for a driver. A dispenser correctly described the difference between confidential and general waste and explained that confidential waste was collected in a designated place. She wasn't clear how it was disposed of. The pharmacy manager believed that it was shredded by one of the pharmacy's directors, who was a pharmacy technician (PT), and usually worked full time at the pharmacy. The pharmacy manager could not locate the shredder, so no destruction could take place until the director returned from annual leave. Some confidential waste was seen mixed with general waste. It was removed when the risk of disclosing people's private information was pointed out.

There was a SOP for safeguarding children and vulnerable adults, but some staff had not signed the training record. So it was not clear whether they would know how to identify problems or deal with them. The RP confirmed that she had completed level 2 training on safeguarding and she said she would discuss any concerns with the superintendent pharmacist (SI). Team members knew they should contact the safeguarding contact at the local Council, or the police in an emergency.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough staff to manage its workload and they complete the essential training they need to do their jobs. But ongoing training is not well organised and does not happen regularly, so the team's knowledge may not always be fully up to date. Team members are comfortable providing feedback to their manager and they receive feedback about their own performance.

Inspector's evidence

The RP was a regular pharmacist who worked four days each week at the pharmacy. Another regular pharmacist worked the other day each week. The pharmacy manager was a qualified dispenser. There were two other NVQ2 qualified dispensers (or equivalent) and two new members of the team on duty at the time of the inspection. One of the new members of the team was an overseas pharmacist who was working as a dispenser until she had completed a conversion course. The other member of staff had not worked in a pharmacy before. She was shadowing other members of the team and the pharmacy manager said all her work was being closely monitored and checked. The pharmacy manager confirmed that both these members of staff would be enrolled onto dispensing assistant courses when they had completed three months at the pharmacy. There were two delivery drivers on the pharmacy team. The SI was present for part of the inspection. He usually worked at the neighbouring pharmacy but explained that he visited the pharmacy periodically and had carried out an assessment two months ago. At that time, he had felt everything was in order. The staffing level was adequate for the volume of work during the inspection and the team were observed working collaboratively with each other. Planned absences were organised on a chart, so that not more than one person was away at a time.

Members of the pharmacy team carrying out the services had completed appropriate training or were being closely supervised. But there was no ongoing training and members of the team were not given protected training time, so there might be gaps in their knowledge. Team members had one-to-one discussions with one of the directors approximately twice a year where their performance and development were discussed, and the director held staff meetings every month or so. Team members confirmed that they would raise concerns with him or the SI. The pharmacy manager held regular meetings on a weekly basis where the workload for the coming week and any other issues were discussed. Concerns could be raised informally at these meetings, but they were not recorded so there was a risk that issues raised would not be addressed. A dispenser said she felt comfortable admitting errors and tried to learn from mistakes. There was a whistleblowing policy.

The RP confirmed she was empowered to exercise her professional judgement and could comply with her own professional and legal obligations. For example, refusing to supply a medicine if she felt it was clinically inappropriate. She said she wasn't under any pressure to achieve targets.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are suitable for the provision of healthcare services, but the lack of cleanliness in some areas detract from the professional image of the pharmacy.

Inspector's evidence

The pharmacy premises were over three floors and were in an adequate state of repair. The front door was locked to prevent people entering the pharmacy from the street. But there was no means of communicating with people standing at the door, such as an intercom, without opening it. There was a main dispensary, a secondary dispensary and an office on the ground floor. There were stockrooms, offices and staff facilities on the upper floors. There was a cleaning rota in place, but some areas of the pharmacy, especially on the upper floors were not very clean. The windows were dirty and did not present a very professional image. The temperature and lighting were adequately controlled. Staff facilities included a small kitchen and two WCs, with wash hand basins and hand wash. There was a separate dispensary sink for medicines preparation with hot and cold running water. Hand washing notices were displayed above the sinks. The pharmacy's website had some information about the pharmacy but there were some details missing such as the GPhC registration number and the name of the SI.

Principle 4 - Services **Standards not all met**

Summary findings

The pharmacy offers services which are adequately managed. It gets its medicines from licensed suppliers and the team carries out some checks to ensure medicines are in suitable condition to supply. But the pharmacy does not always store all of its medicines appropriately. So it cannot provide assurance that they are always kept in good condition or safe from unauthorised access.

Inspector's evidence

Services provided by the pharmacy were advertised in the window and on the pharmacy's website. The pharmacy mainly supplied medicines to people in care homes. The pharmacy team was clear what services were offered and where to signpost people to a service not offered. The pharmacy was located close to another pharmacy, owned by the same company, which was a traditional pharmacy offering face-to-face services.

There was a home delivery service with associated audit trails. Each delivery was recorded, and a signature was generally obtained from the recipient. A note was left if nobody was available to receive the delivery and the medicine was returned to the pharmacy. A member of staff from the care home was required to sign to confirm they had received their deliveries.

Space was adequate, and the workflow 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. The RP was aware of the valproate pregnancy prevention programme and said she would check this with any patients in the at-risk group. She was aware of the requirement to highlight the care card contained in original packs of valproate to ensure people received the appropriate information and counselling.

Multi-compartment compliance aid packs were provided as well as single dose medications on racks. Medicine descriptions were included on medicines administration record (MAR) charts which were provided with all compliance aid packs, to enable identification of the individual medicines. Packaging leaflets were not usually included, so people might not easily access additional information about their medicines. Disposable equipment was used.

Most of the current stock of CDs were stored in two CD cabinets which were securely fixed to the wall/floor. The keys were under the control of the responsible pharmacist during the day. Date expired and patient returned CDs were not stored sufficiently securely and there was a risk of unauthorised access. Actions were taken during the inspection to address these risks, including the destruction of a large quantity of patient returned CDs using denaturing kits.

Recognised licensed wholesalers were used to obtain stock medicines. Medicines were stored in their original containers. The pharmacy manager confirmed that the minimum and maximum temperatures

of the medical fridge were being recorded regularly, but he could not locate the records and the member of staff responsible for this activity was not present. The maximum temperature was reading 11 degrees Celsius which was outside the required range. The fridge remained within range for the duration of the inspection. Date checking was carried out and documented. Short-dated stock was highlighted. Dates had been added to opened liquids with limited stability. Some expired and unwanted medicines had been segregated and placed in designated bins. But a large quantity of stock which had been returned from the care homes had been placed in plastic tote trays, rather than the designated bins, so there was a risk that these medicines might be confused with current stock, rather than waste medicines. This was not in line with the disposal of patient returned medicines SOP where the procedure was that the medicines were placed directly into the designated bins for disposal.

One of the directors received drug alerts and recalls via email messages. When he was working at the pharmacy he printed them off for the team to action. The team said that when he was absent, he forwarded them to the pharmacy's email address if relevant. However, team members did not know where previous alerts and recalls were stored, so could not provide assurance that the appropriate action had been taken and would not easily be able to respond to queries.

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.

Inspector's evidence

Current versions of the British National Formulary (BNF) and BNF for children were not available, but the RP said she used an App on her mobile phone to access the electronic BNF. And there was internet in the pharmacy to access the most up-to-date reference sources. There was a clean medical fridge. All electrical equipment appeared to be in good working order. Patient medication records (PMRs) were password protected. 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.

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.