General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Moor Park Pharmacy, 47 Garstang Road, PRESTON, Lancashire, PR1 1LA

Pharmacy reference: 1106287

Type of pharmacy: Community

Date of inspection: 14/01/2020

Pharmacy context

This is a community pharmacy located on a major road north of Preston City Centre. The local GP surgery is about 100 yards away. The pharmacy dispenses NHS prescriptions, private prescriptions and sells over-the-counter medicines. It also provides a minor ailment service. A number of people receive their medicines in 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 met	1.7	Good practice	Members of the team are given training so that they know how to keep private information safe.
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	Multicompartment compliance aids are left unlabelled for some time which may increase the risk of error. One of the pharmacy's medicine fridges does not have a thermometer. So the pharmacy team cannot show whether the medicines are being stored appropriately.
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 generally 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 record things that go wrong, but the records do not include details of action they have taken, so they may miss some learning opportunities.

Inspector's evidence

There was a current set of standard operating procedures (SOPs) which had been recently reviewed by the pharmacist manager. Members of the pharmacy team had signed to say they had read and accepted the SOPs. But the SOPs did not always make clear which members of the pharmacy team they applied to. So members of the team may not always know where responsibility lies.

Dispensing errors were recorded electronically on the national reporting system 'NRLS'. The pharmacist said he was not aware of any errors which had recently occurred. Members of the pharmacy team were able to explain the process of recording and investigating an error. Near miss incidents were recorded on a paper log. The pharmacist explained that he would discuss each incident with the pharmacy team at the time they were discovered, as not many were made. He would also take action to avoid errors being repeated, depending on the error made and its frequency. For example, codeine 15mg and 30mg tablets had been moved away from each other to prevent a picking error. But details about the action taken were not recorded, so learning opportunities may be missed.

A dispenser was able to explain what her 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 pharmacist manager. A current certificate of professional indemnity insurance was seen.

Records for private prescriptions, emergency supplies and unlicensed specials appeared to be in order. But the RP records did not include the times the RPs ended their tenure. So the pharmacy may not be able to demonstrate who the RP was at a specific point in time. Controlled drugs (CDs) registers were maintained. Two random balances were checked, and both found to be accurate. Patient returned CDs were recorded in a separate register.

An information governance (IG) policy was available. The pharmacy team received GDPR training and each member had signed a confidentiality agreement. When questioned, a dispenser was able to describe how confidential waste was segregated to be removed by a waste carrier. A privacy notice was on display in the retail area and described how people’s data was handled.

Safeguarding procedures were available in a safeguarding folder and included the contact details of the local safeguarding board. The pharmacy team had in-house training and the pharmacist had completed level 2 safeguarding training. A 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 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 two pharmacists – one of whom was the pharmacy manager and one of whom was the superintendent (SI), a pre-registration pharmacist (pre-reg), three dispensers and a driver. All members of the team had completed the necessary training for their roles. The normal staffing level was a pharmacist and three dispensary staff. The volume of work appeared to be managed. Staffing levels were maintained using a staggered holiday system. Relief staff from local branches could be requested, but the pharmacist said they were not often needed.

Members of the pharmacy team completed some additional training, for example they had recently completed a training pack about Children's oral health. They said they completed training often but could not find the training records to show what training had been completed. So it was unclear whether learning needs were being fully addressed.

A dispenser gave examples of how she would sell a pharmacy only medicine using the WWHAM questioning technique, refuse co-codamol sales she felt were inappropriate and refer people to the pharmacist if needed. The pharmacist said he felt able to exercise his professional judgment and this was respected by the other pharmacists and the pharmacy team. A dispenser said she received a good level of support from the pharmacist and felt able to ask for further help if she needed it.

A dispenser said she would receive on the job feedback from the pharmacist. But there was no appraisal programme, so development needs may not always be identified. Staff were aware of the whistleblowing policy and said that they would be comfortable reporting any concerns to the manager or SI. There were no targets set by the company.

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 clean and tidy, and appeared adequately maintained. The size of the dispensary was sufficient for the workload and access to it was restricted by use of a gate. 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 electric heaters. Lighting was sufficient. The staff had access to a kettle, microwave, and WC facilities.

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

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

Summary findings

The pharmacy's services are easy to access. And it manages and provides them safely. But medicines packed in multi-compartment compliance aids are often left unlabelled for some time, which may increase the risk of error. And some medicines are stored in a fridge that does not have a thermometer. So members of the pharmacy team do not know if the medicines are always stored appropriately to keep them in good condition.

Inspector's evidence

Access to the pharmacy was suitable for wheelchair users. There was also wheelchair access to the consultation room. 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 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. A seperate signature was obtained for the delivery of CDs.

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 used 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. High-risk medicines (such as warfarin, lithium and methotrexate) were not routinely highlighted. So the pharmacy team were not always aware when they were being handed out in order to check that the supply was suitable for the patient. 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 an audit had been completed. He said he would speak to any patients who were at risk to make sure they were aware of the pregnancy prevention programme, which would be recorded on their PMR.

Some medicines were dispensed in multi-compartment compliance aids. Before a person was started on a compliance aid the pharmacy would refer them to their GP to complete an assessment about their suitability. A record sheet was kept for each patient, containing details about 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. But the compliance aids were not always labelled with medication descriptions. And patient information leaflets (PILs) were not routinely supplied. So people may not be able to identify the individual medicines or have all of the information they need to take the medicines safely. Compliance aids were assembled in advance of receiving a

prescription and were stored without any dispensing labels attached. This does not meet the current labelling requirements and may increase the risk of an error.

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. Stock was date checked on a 3-month rotating cycle. A date checking matrix was on display, but it was incomplete. A dispenser said she had recently checked the expiry dates of their stock but had not signed the records. Shelving was cleaned as part of the process and short dated stock was highlighted using a sticker. Liquid medication had the date of opening written on. A spot check of the dispensary stock did not find expired medicines.

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 were two clean medicine fridges. One of the fridges had a thermometer and the minimum and maximum temperatures were being recorded daily. But the second fridge did not have a thermometer. So the pharmacy team were not able to monitor the temperature to make sure the medicines remained fit for purpose. 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.

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.