General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: London Road Pharmacy, Unit 1, 157 London Road, MACCLESFIELD, Cheshire, SK11 7SP

Pharmacy reference: 1106664

Type of pharmacy: Community

Date of inspection: 18/10/2019

Pharmacy context

This is a community pharmacy in the town of Macclesfield, Cheshire. The pharmacy sells over-the-counter medicines and dispenses NHS prescriptions. It also dispenses private prescriptions. The pharmacy team offers advice to people about minor illnesses and long-term conditions. And it offers services including seasonal flu vaccinations, medicines use reviews (MURs), a substance misuse service and the NHS New Medicines Service (NMS). It also supplies medicines in multi-compartmental compliance packs to people living in their own homes.

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 has written procedures to help the team protect the safety and wellbeing of people who access its services. It mostly keeps the records it must have by law. And it keeps people's private information secure. The pharmacy team members have some tools available to them to help safeguard the welfare of vulnerable adults and children. The team members discuss and learn from the mistakes that happen whilst dispensing. And they take some steps to make sure they don't repeat these errors.

Inspector's evidence

The pharmacy had a set of standard operating procedures (SOPs). There was an index. And so, it was easy to find a specific SOP. Each SOP was reviewed every two years. This ensured that they were up to date. And they were due for the next review in December 2019. There were SOPs for procedures such as taking in and handing out prescriptions, responsible pharmacist (RP) regulations and dispensing. The team members described how they would ask the pharmacist if there was a task they were unsure about. Or felt unable to deal with. Most, but not all, of the team members had signed the SOPs that were relevant to their role. This was to confirm that they understood its contents.

The team members regularly completed records of near miss errors they had made while dispensing. They recorded details such as the time, date of the error, contributing factors and learning points. They also recorded if the error involved medicines that looked or sounded like each other, known as LASA medicines. For example, bisoprolol and bisacodyl. But often the contributory factor section of the log was left blank, and the learning points recorded were often non-specific. For example, on several occasions the team recorded the learning point as ‘read prescription’. The near miss error logs were analysed each month by the pharmacy’s senior dispenser. Her goal was to identify any trends or patterns in the errors and discuss them with the team during a team meeting. The dispenser explained that the meetings were an opportunity for her to raise awareness of common mistakes. For example, the team had recently made a few errors with the strengths of zopiclone. To tackle the problem, they decided to separate zopiclone from other ‘z’ medicines. And this measure had reduced the number of similar errors happening. The pharmacy had a process to record dispensing errors that had been given out to people. And it kept a copy of the report in the pharmacy for future reference. The report template included the details of who was involved, what happened, why it happened, and what actions the pharmacy intended to do to prevent a similar error happening again. But the team was unsure of how they would complete the process as they explained it was the responsibility of the regular pharmacist, who was not working on the day of the inspection.

The pharmacy advertised how people could make comments, suggestions and complaints in a leaflet in the retail area which people could take away with them. It obtained feedback from people who used the pharmacy through verbal comments and a customer satisfaction survey. But the team was unable to give any examples of improvements to the pharmacy following feedback from people.

The pharmacy had up-to-date professional indemnity insurance. The responsible pharmacist notice displayed the name and registration number of the responsible pharmacist on duty. Entries in the responsible pharmacist record complied with legal requirements. The pharmacy kept complete records of private prescription and emergency supplies. The pharmacy kept controlled drugs (CDs) registers. And they were completed correctly. The pharmacy team checked the running balances against physical

stock when they dispensed stock, or they received new stock. A physical balance check of two random CD items matched the balance in the register. The pharmacy kept complete records of CDs returned by people to the pharmacy. The pharmacy held certificates of conformity for unlicensed medicines, but they were not always completed in line with the requirements of the Medicines & Healthcare products Regulatory Agency (MHRA).

The team held records containing personal identifiable information in areas of the pharmacy that only team members could access. Confidential waste was placed into a separate bin to avoid a mix up with general waste. The confidential waste was periodically destroyed via a third-party contractor. The pharmacy outlined to people using the pharmacy how it stored and protected their information, via a notice on a wall in the retail area. The team members understood the importance of keeping people's information secure. The pharmacist on duty had completed training on the safeguarding of vulnerable adults and children up to level 2 via the Centre for Pharmacy Postgraduate Education. The team members gave several examples of symptoms that would raise their concerns in both children and vulnerable adults. A team member explained how she would discuss her concerns with the pharmacist on duty, at the earliest opportunity. The pharmacy had written guidance on how to manage or report a concern and the contact details of the local safeguarding team affixed to a dispensary wall.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy team members have the appropriate qualifications and skills to provide the pharmacy's services. They work well together to manage their workload and to ensure people receive a high quality service. The pharmacy supports its team members to ensure their knowledge and skills are up to date. It achieves this by providing its team members with a training programme and regular appraisals of performance. They can make suggestions to improve the pharmacy's services. And they feel comfortable to raise professional concerns when necessary.

Inspector's evidence

At the time of the inspection, the responsible pharmacist was a locum pharmacist. And she was supported by and NVQ2 qualified senior dispenser and a part-time trainee pharmacy assistant. The regular pharmacist was also the pharmacy's manager and worked four days a week. Three other part-time pharmacy assistants were not present during the inspection. The pharmacy manager organised the team rotas in advance to ensure enough support was available during the pharmacy's busiest times. The team members were observed managing the workload well and had a manageable workflow. They were seen asking the pharmacist for support, especially when they were presented with a query for the purchase of an over-the-counter medicine. They were observed acknowledging people who were waiting to be served as they arrived at the retail counter. They informed people of the waiting time for prescriptions to be dispensed and took time to speak with them if they had any queries. The team members felt they had enough staff to manage the workload efficiently, especially when all the team members were available to work. They said they could speak to the pharmacy's owner if they needed extra support and they often received additional support if they felt they were falling behind with their workload. And to make sure they provided the high quality of service they aimed to achieve. The team members often worked additional hours to cover absences and holidays. And they could also call upon the help of team members from the company's other pharmacies if they felt the need to do so. They did not take holidays in the run up to Christmas to make sure the pharmacy had enough team members working, as this was the busiest time of the year for the pharmacy.

The team members had access to an online training system called Virtual Outcomes. The system contained several modules, some of which were mandatory to complete, and some could be accessed voluntarily or in response to an identified training need. Each team member had personal electronic log of the training they completed. There was usually a short quiz at the end of each module which the team members were required to pass to indicate they had understood the module and were competent in following it. The team members did not get protected time to complete training, but they regularly completed training when the pharmacy was quiet. The pharmacy had an appraisal process in place for its team members. The appraisals took place every year. The appraisals were an opportunity for the team to discuss which aspects of their roles they enjoyed, where they wanted to improve and if they wanted to give any feedback to improve the services the pharmacy offered. The senior dispenser explained that she had started the role following her last appraisal, during which she asked for more responsibility. She had been given the responsibility of completing additional tasks such as the monthly analysis of the near miss errors.

The team attended regular meetings and discussed topics such as company news, targets and patient safety, when the pharmacy was quiet. If a team member was not present during the discussions, they

were updated the next time they attended for work. The team members felt comfortable to give feedback to the regular pharmacist or the pharmacy's owner, to help improve the pharmacy's services. The team members were able to discuss any professional concerns with the regular pharmacist or the pharmacy's owner. The pharmacy had a whistleblowing policy. The team was set various targets to achieve. These included the number of prescription items they dispensed and the number of services they provided, for example, medicine use reviews. The targets did not impact on the ability of the team to make professional judgements.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is kept secure and is well maintained. The premises are suitable for the services the pharmacy provides. It has a sound-proofed room where people can have private conversations with the pharmacy's team members.

Inspector's evidence

The pharmacy had a large retail space and a large dispensary. It was clean and was professional in its appearance. The building was easily identifiable as a pharmacy from the outside. The dispensary was tidy and well organised during the inspection and the team had ample bench space to organise the workflow. Floor spaces were kept clear to minimise the risk of trips and falls. There was a clean, well-maintained sink in the dispensary for medicines preparation and staff use. There was a WC which had a sink with hot and cold running water and other facilities for hand washing. There was a sink in the staff area used for drink and food preparation. The pharmacy had a sound-proofed consultation room which contained two seats, a sink and a computer terminal. The room was smart and professional in appearance and was signposted by a sign on the door. The temperature was comfortable throughout the inspection. Lighting was bright throughout the premises.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy has services that are are easily accessible to people. It engages with people using the pharmacy to help them improve their health. The team members take steps to identify people taking high-risk medicines. And, they provide these people with appropriate advice to help them take these medicines safely. The pharmacy provides medicines to some people in multi-compartment compliance packs to help them take them correctly. And it appropriately manages the risks associated with the service. The pharmacy sources its medicines from licenced suppliers. And it stores and manages its medicines appropriately.

Inspector's evidence

The pharmacy was accessible via a step from the street, to a push/pull entrance door. A ramp was available to help people who had prams or used wheelchairs. The pharmacy could supply people with large print dispensing labels if needed. The pharmacy advertised its services and opening hours in the main window. It stocked a wide range of healthcare related leaflets in the retail area, which people could select and take away with them. The pharmacy was a healthy living pharmacy and there was a healthy living zone next to the pharmacy counter. The zone had an eye-catching display of information about lung infections and the symptoms that people should report to their doctor. The team members described how several people had engaged with the display. And how they then had an opportunity to speak to people and give healthy living advice.

The team members regularly used various stickers during dispensing and they used these as an alert before they handed out medicines to people. For example, to highlight interactions between medicines or the presence of a fridge line or a controlled drug that needed handing out at the same time. The team members signed the dispensing labels when the dispensing and checking processes were complete. And so, a robust audit trail of the process was in place. They used baskets to hold prescriptions and medicines. This helped the team members stop people’s prescriptions from getting mixed up. They recorded the date that CD prescriptions expired on CD alert stickers, which they attached to medication bags. This system helped the team members check the dates and helped prevent them from handing out any CDs to people after their prescription had expired. Owing slips were given to people on occasions when the pharmacy could not supply the full quantity prescribed. One slip was given to the person. And one kept with the original prescription for reference when dispensing and checking the remaining quantity. The pharmacy kept records of the delivery of medicines it made to people. The records included a signature of receipt. So, there was an audit trail that could be used to solve any queries. A note was posted to people when a delivery could not be completed. The note advised them to contact the pharmacy.

The pharmacy supplied medicines in multi-compartmental compliance packs for around 60 people living in their own homes. And the pharmacy supplied the packs to people on either a weekly or monthly basis. The team members were responsible for ordering the prescriptions. And they did this around a week in advance. And then they cross-referenced the prescription with the person's electronic medication record to ensure it was accurate. The team members queried any discrepancies with the person’s prescriber. They dispensed the packs on a rear bench, located away from the retail counter. This allowed them to complete the dispensing process without being distracted. The packs had information which listed the medicines in the packs and the directions. The pharmacy supplied

information to help people visually identify the medicines. For example, the colour or shape of the tablet or capsule. It also routinely provided patient information leaflets with the packs. The team members recorded the details of any changes such as dosage increases or decreases. They kept the details of when the change was authorised and who had authorised it.

The pharmacy dispensed high-risk medicines for people such as warfarin. The team members used alert stickers attached to people's medication bags to remind them that the bag contained a high-risk medicine. They then brought the bag to the attention of the pharmacist. The pharmacist gave the person collecting the medicine additional advice if there was a need to do so. The team members were aware of the pregnancy prevention programme for people who were prescribed valproate and of the risks. They demonstrated the advice they would give people in a hypothetical situation. The team had access to literature about the programme that they could provide to people to help them take their medicines safely. And they used a shelf alert sticker next to where valproate medicines were stored, to remind the team to provide information cards to people. The team had completed a check to see if any of its regular patients were prescribed valproate. And met the requirements of the programme. One person had been identified. The pharmacy used clear bags to store dispensed insulin and controlled drugs. This allowed the team member and the person collecting the medicine to undertake a final visual check when it was handed out.

Pharmacy medicines (P) were stored behind the pharmacy counter. So, the pharmacist could supervise sales appropriately. The pharmacy stored its medicines in the dispensary tidily. Every three months, the team members checked the expiry dates of its medicines to make sure none had expired. No out-of-date medicines were found after a random check. And the team members used alert stickers to help identify medicines that were expiring within the next 12 months. They recorded the date liquid medicines were opened on the pack. So, they could check they were in date and safe to supply. The pharmacy had a robust procedure in place to appropriately store and then destroy medicines that had been returned by people. And the team had access to CD destruction kits.

The team were not currently scanning products or undertaking manual checks of tamper evident seals on packs, as required under the Falsified Medicines Directive (FMD). The team had received some training on how to follow the directive. The team was unsure of when they were to start following the directive. Drug alerts were received via email to the pharmacy and actioned. The alerts were printed and stored in a folder. And the team kept a record of the action it had taken. The pharmacy checked and recorded the fridge temperature ranges every day. And a sample checked were within the correct ranges. It had two CD cabinets in place. And they were secured and of an appropriate size. The medicines inside were well organised.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy's equipment is well maintained and appropriate for the services it provides. The pharmacy uses its equipment to protect people's confidentiality.

Inspector's evidence

The pharmacy had copies of the BNF and the BNF for children for the team to use. And the team had access to the internet as an additional resource. The pharmacy used a range of CE quality marked measuring cylinders. The team members used tweezers and rollers to help dispense multi-compartmental compliance packs. The fridges used to store medicines were of an appropriate size. And the medicines inside were organised in an orderly manner. Prescription medication waiting to be collected was stored in a way that prevented people's confidential information being seen by members of the public. And computer screens were positioned to ensure confidential information wasn't seen by people. The computers were password protected to prevent any unauthorised access. The pharmacy had cordless phones, so the team members could have conversations with people in private. The electrical equipment looked to be in good working order.

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.