General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: HBS Pharmacy, Newton Drive Health Centre, Newton Drive, BLACKPOOL, Lancashire, FY3 8NX

Pharmacy reference: 1109046

Type of pharmacy: Community

Date of inspection: 17/07/2019

Pharmacy context

This is a community pharmacy next to a medical centre. It is situated in the residential area of Normoss, in Blackpool. The pharmacy dispenses NHS prescriptions, private prescriptions and sells over-the-counter medicines. It also provides a range of services including seasonal flu vaccinations and a private smoking cessation service. A number of people receive their medicines in multi-compartment compliance aids.

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. Members of the team record things that go wrong and discuss them to help identify learning and reduce the chances of similar mistakes happening again. They are given training so that they know how to keep private information safe. The pharmacy keeps the records it needs to by law.

Inspector's evidence

There was a current set of Standard Operating Procedures (SOPs) which were last issued in July 2018, and their stated date of review was July 2020. Some of the pharmacy team had not signed the SOPs to say they had read and accepted them. So it was not clear whether they fully understood what was expected of them.

Dispensing errors were recorded electronically and submitted to the superintendent (SI). An example of an error involved selecting the incorrect strength of bisoprolol tablets. The pharmacist had investigated the error and taken action to help reduce the risk of further errors by moving different strengths of bisoprolol tablets away from one another. Near miss errors were recorded on a paper log. The pharmacist said she would usually review error records and discuss any learning points with the pharmacy team and highlight common errors. But reviews had not been recorded since October 2018 so some learning opportunities may have been missed.

Roles and responsibilities of the pharmacy team were described in individual SOPs. The dispenser was able to describe what her responsibilities were and was also 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. This was described in the practice leaflet which advised people they could give feedback to members of the pharmacy team. Complaints were recorded to be followed up by the pharmacist or the head office.

The pharmacy has provided evidence that current professional indemnity insurance was in place. Controlled Drugs (CDs) registers were maintained. Running balances were recorded and checked monthly. The balance of MST 5mg MR tablets, Fentanyl 12mcg patches and Shortec 5mg capsules were checked and found to be accurate. Patient returned CDs were recorded in a separate register. Records for the RP, private prescriptions, emergency supplies and unlicensed specials appeared to be in order.

An information governance (IG) policy was available which had been read by the pharmacy team. A dispenser said she had signed a confidentiality agreement in her contract. When questioned, the dispenser was able to describe how confidential waste was segregated to be destroyed using the on-site shredder. A sign was displayed in the retail area explaining how the pharmacy handled people's information.

Safeguarding procedures were available and had been read by the pharmacy team. The pharmacist said she had completed level 2 safeguarding training. Contact details of the local safeguarding board were available. 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 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, five dispensers – one of whom was in training, and a medicine counter assistant (MCA). The pharmacy team were appropriately trained or in accredited training programmes. Between the core hours of 9am and 6pm, the normal staffing level was a pharmacist, a counter assistant and two dispensers. Outside of these hours the pharmacist worked with just one member of staff. The volume of work appeared to be managed. Staffing levels were maintained by part-time staff and a staggered holiday system. Relief staff could be requested from another branch if needed.

The pharmacy team completed some additional training, for example they had recently completed a training pack about children's oral health. Staff were allowed learning time to complete this training. 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 she would sell a pharmacy only medicine using the WWHAM questioning technique, refuse sales she felt were inappropriate and refer people to the pharmacist if needed. The pharmacist said she felt able to exercise her professional judgement and this was respected by the pharmacy team and the company. A dispenser had recently commenced her employment with the pharmacy. She said she received a good level of support from the pharmacy team and felt able to ask for help. Appraisals were provided yearly by the company.

The staff held daily huddles to discuss operational matters, for example about managing the current workload and any issues that had arisen such as errors or complaints. A communications diary was used to record important information so that it could be shared with staff who were not present. Staff were aware of the whistle blowing policy and said that they would be comfortable reporting any concerns to the head office. There were targets set for services such as MURs. The pharmacist said she 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 clean and appeared adequately maintained. But the dispensary was cluttered with boxes, which presented a trip hazard for staff. The size of the dispensary was sufficient for the workload. A sink was 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 temperature was controlled by the use of air conditioning units. 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. There was a computer, desk, seating, adequate lighting, and a wash basin. It appeared cluttered with boxes containing pharmacy sundries, which detracted from the professional image. 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 appropriate sources, stores them appropriately and carries out regular checks to help make sure that they are in good condition. But the pharmacy team does not always identify people who receive higher risk medicines. So it might not always check that the medicines are still suitable, or give people advice about taking them.

Inspector's evidence

Access to the pharmacy was level via a single door and was suitable for wheelchair users. There was wheelchair access to the consultation room. A poster and pharmacy practice leaflets gave information about the services offered. 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 using a signposting folder. The pharmacy opening hours were displayed at the entrance of the pharmacy and a range of leaflets provided information about various healthcare topics.

A repeat prescription service was offered where patients would contact the pharmacy to order their medication. A record of requested medication was kept, and any missing items were queried with the GP surgery. 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. Some deliveries were made to an alternative address, but this was only done at the request of the patient and consent was obtained on every occasion. Unsuccessful deliveries would be returned to the pharmacy and a card posted through the letterbox indicating the pharmacy had attempted a delivery. CDs were recorded on a separate delivery sheet for individual patients and a separate signature was obtained

Dispensed by and checked by boxes were initialled on dispensing labels to provide an audit trail. Dispensing baskets were used for segregating individual patients' 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. 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 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 during pregnancy. Educational material was available to hand out when the medicines were supplied. The pharmacist said she would speak to any patients who were at risk and 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 MDS compliance aids. A record sheet was kept for all MDS patients, containing details of 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 MDS packs were labelled with a dispensing check audit trail. But MDS packs were not 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.

Medicines were obtained from licensed wholesalers, with unlicensed medicines sourced from a special's manufacturer. The pharmacy was not yet meeting the safety features of the falsified medicine directive (FMD), which is now a legal requirement. Equipment had been delivered but had not been installed. The pharmacist said the company were arranging for the installation of the scanners and the software. So the pharmacy team were not yet able to commence routine safety checks of medicines. Stock was date checked on a monthly basis. A date checking matrix was signed by staff as a record of what had been checked, and shelving was cleaned as part of the process. Short dated stock was highlighted using a sticker and recorded in a diary for it to be removed at the start of the month of expiry. Liquid medication did not always have the date of opening written on, including a bottle of morphine sulphate oral solution which expired within 3 months of opening. So members of the pharmacy team may not know how long the medicines had been open or whether they remained fit for purpose.

Controlled drugs were stored in the CD cabinet. CD denaturing kits were available for use. There was a clean medicines fridge with a minimum and maximum 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. Alerts were printed and stored in a folder for reference.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy's team members have 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 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 June 2019. 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.

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.