General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Queens Road Pharmacy, 238 Queens Road, HALIFAX, West Yorkshire, HX1 4NE

Pharmacy reference: 1109432

Type of pharmacy: Community

Date of inspection: 07/11/2019

Pharmacy context

The pharmacy is in a parade of shops in a residential area of Halifax. Pharmacy team members dispense NHS prescriptions and sell a range of over-the-counter medicines. They offer services including medicines use reviews (MURs) and the NHS New Medicines Service (NMS). And, they supply medicines to people in multi-compartment compliance packs. The pharmacy provides a substance misuse service, including supervised consumption and needle exchange.

Overall inspection outcome

Standards not all met

Required Action: Improvement Action Plan

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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 does not have written procedures covering all its professional services and processes. Such as near miss and dispensing incident reporting. And for its complaints procedures. Pharmacy team members do not always follow the written procedures. Such as processes for dispensing into multi-compartment compliance packs. This increases risks in the way the team works.
		1.2	Standard not met	Pharmacy team members record some mistakes that happen. But the records are not consistent. And they sometimes record no errors for several months. They do not regularly take learning from the mistakes. And, they do not routinely analyse the information they collect or make changes to help prevent mistakes happening again.
		1.6	Standard not met	The pharmacy keeps most of the records required by law. But, it does not keep other records that help the team to identify and manage risks with its services. For example, the pharmacy doesn't always keep up-to-date records of stock balances for some controlled drugs. When complete these help manage safe and effective services.
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	4.2	Standard not met	The pharmacy doesn't manage all its services appropriately. It delivers medicines to people without adequate controls or audit trails in place. And, it does not adequately assess or manage the risks of posting medicines or leaving them unattended.
		4.3	Standard not met	The pharmacy does not store all its medicines appropriately. Some medicines are not stored in the manufacturer's original packs. And the batch numbers and expiry dates cannot be identified.

Principle	Principle finding	Exception standard reference	Notable practice	Why
				Pharmacy team members don’t regularly check the expiry date on medicines. And, there is evidence of out of date medicines on the shelves. So, there is a risk they can supply medicines to people that may not be safe to use.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

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

Summary findings

The pharmacy has some written procedures available to help manage the risks to its services. But it doesn't have procedures covering some of its key professional services. And pharmacy team members do not always follow the written procedures that the pharmacy does have. So, pharmacy team members may not be working in the safest and most effective way. The pharmacy doesn't have a written procedure to support pharmacy team members to record mistakes that happen during dispensing. The recording and learning after these mistakes is inconsistent. And the team doesn't always keep its records of these mistakes in the pharmacy to refer to. The pharmacy keeps most of the records required by law. But it does not keep other records, such as stock balances for all its higher risk medicines. This means it is difficult for the team to manage these medicines in a safe and effective way. The pharmacy protects people's privacy and confidentiality. And pharmacy team members generally know how to safeguard the welfare of children and vulnerable adults.

Inspector's evidence

The pharmacy had a set of standard operating procedures (SOPs) in place. The sample checked were last reviewed in 2018. And the next review was scheduled for 2019. The superintendent pharmacist (SI) confirmed they were reviewed every year. Pharmacy team members had read and signed the SOPs after the review in 2017. But not after the last review in 2018. The procedures instructed pharmacy team members to refer to a separate document which defined the roles and responsibilities of each team member. The document was available. But the pharmacy had not populated it with specific information about the pharmacy's team members. Pharmacy team members said they defined their roles and daily tasks verbally.

The pharmacist described how he highlighted near miss errors made by the pharmacy team when dispensing. But the pharmacy did not have a documented procedure about how to respond to near miss errors. Pharmacy team members recorded their own mistakes. But there were few records to see. The latest records available were from September 2019. And, there were no records from between November 2017 and August 2019. The superintendent pharmacist (SI) said that errors were recorded. But the other pharmacy owner had removed the records to analyse. A dispenser gave an example of separating ramipril tablets and capsules on the pharmacy's shelves after a picking error. The latest record of analysis was from June 2018. The SI said that analysis of near miss data had not been done since. The key patient safety issue identified in the analysis example available was the wrong bag label being attached to bags of dispensed medicines. Pharmacy team members had discussed the issue. And, they had changed their processes to make sure that bag labels were not attached to the edges of baskets to prevent them sticking to the wrong basket or bag. The pharmacy did not have a documented procedure for dealing with dispensing errors that had been given out to people. And, there were no records of dispensing errors available to see. The SI said that dispensing error had happened and had been recorded. But he could not produce the records during the inspection.

The pharmacy did not have a documented procedure to deal with complaints handling and reporting. And, it did not advertise to people how they could make a complaint about the pharmacy. This was discussed, and the SI said he would print some more copies of the pharmacy's practice leaflet. Pharmacy team members said they collected feedback from people verbally. But they could not give any examples of any changes made in response to feedback to help improve their services.

The pharmacy had up-to-date professional indemnity insurance in place. And displayed a certificate of insurance. The pharmacy kept controlled drug (CD) registers complete and in order. It kept running balances in some registers. And these were audited against the physical stock quantity after each entry. But, stock not used frequently was not regularly audited. For example, the register for Physeptone 5mg tablets was last audited on the 30 October 2018. And, the register for Sevredol 10mg tablets was last audited on the 26 February 2019. The pharmacy did not maintain a running balance in the register for sugared methadone. And, a running balance had been kept in the sugar free methadone register since the 19 September 2019, but not before. The pharmacy kept and maintained a record of CDs returned by people for destruction in a notebook, but not in a pre-printed book or register specifically designed for the records. The examples seen recorded the necessary information. It maintained a responsible pharmacist record on paper. And, the record was complete and up to date. The pharmacist displayed their responsible pharmacist notice to people. The pharmacy team monitored and recorded fridge temperatures daily. They kept private prescription records in a paper register and electronically. There was not one clear legal record. The SOP instructed pharmacy team members to record private prescriptions in a paper register. But, from a sample of private prescriptions, four records were missing from the register. On further investigation, the SI found they had been recorded electronically instead. In the samples of records seen, pharmacy team members did not always accurately record the date on the prescription. They recorded emergency supplies of medicines electronically. But, in the samples seen, the records made often did not state a reason for making an emergency supply.

The pharmacy kept sensitive information and materials in restricted areas. And, it incinerated confidential waste. The pharmacy team had been trained to protect privacy and confidentiality. The SI had delivered the training verbally. Pharmacy team members were clear about how important it was to protect confidentiality. But there was no documented procedure in place detailing requirements under the General Data Protection Regulations (GDPR) or for information governance.

Pharmacy team members were asked about what they would do if they had a safeguarding concern about a child or vulnerable adult. They gave some brief explanations about the symptoms that would raise their concerns. And, they would raise their concerns with the pharmacist. The pharmacist said he would raise any concerns with local safeguarding teams. And, he would use the internet to find their contact details. The pharmacy did not have a documented procedure in place to instruct team members about what to do in the event of a concern. And, pharmacy team members had not completed any formal training. But, they had been provided with some training verbally by the pharmacists. The pharmacist had last completed training in 2017. This was discussed with the SI. And, he gave an assurance that formal training would be provided for all pharmacy team members as soon as possible.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy supports its pharmacy team members to complete relevant qualification training for their roles. So, the team has the appropriate skills for the services provided. The pharmacy team members complete ad-hoc supplementary training. And, they learn from the pharmacist and each other to keep their knowledge and skills up to date. Pharmacy team members feel comfortable making suggestions to help improve pharmacy services. But they don't know how to raise concerns anonymously if they need to.

Inspector's evidence

At the time of the inspection, the pharmacy team members present were the superintendent pharmacist (SI), a trainee dispenser and a pharmacy student. The pharmacy also had another pharmacist owner who worked at the pharmacy regularly. The SI explained the pharmacy was currently recruiting a full-time dispenser to replace someone who had recently left. Pharmacy team members completed training ad-hoc outside of their accredited training courses. They did this by reading various trade press materials and having regular discussions with the pharmacist owners. The pharmacy did not have a formal appraisal or performance review process. Pharmacy team members described how they raised any learning needs with the pharmacist owner and SI informally. And, they would teach them and signpost them to relevant resources.

A dispenser explained that she would raise professional concerns with the pharmacist owner or SI. She felt comfortable raising a concern. And confident that her concerns would be considered, and changes would be made where they were needed. The pharmacy did not have a whistleblowing policy. And, pharmacy team members did not know how they would raise a concern anonymously.

Pharmacy team members communicated with an open working dialogue during the inspection. They explained they were comfortable suggesting changes to help improve the way they provided services. But, they could not give any examples of any suggestions they had made. The pharmacy owner and SI did not ask the team to achieve any targets.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean and generally suitably maintained. It provides a suitable space for the services provided. And, it has a room where people can speak to pharmacy team members privately.

Inspector's evidence

The pharmacy was clean and well maintained. All areas of the pharmacy were tidy and well organised. And the floors and passage ways were free from clutter and obstruction. There was a safe and effective workflow in operation. And clearly defined dispensing and checking areas. It kept equipment and stock on shelves throughout the premises.

The pharmacy had a private consultation room available. The pharmacy team used the room to have private conversations with people. The room was signposted by a sign on the door.

There was a clean, well maintained sink in the dispensary used for medicines preparation. There was a toilet, with cold running water and other facilities for hand washing. But the pharmacy did not have hot running water at the toilet sink. There was an electric water heater. But it did not work. Pharmacy team members said they used the toilet sink to wash their hands using cold water. This was discussed with the superintendent pharmacist (SI). And, he gave an assurance that the water heater would be repaired or replaced as soon as possible. The pharmacy had hot water available at the sink in the dispensary. Heat and light in the pharmacy was maintained to acceptable levels. The overall appearance of the premises was professional, including the exterior which portrayed a professional healthcare setting. The professional areas of the premises were well defined by the layout and well signposted from the retail area.

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

Summary findings

The pharmacy's services are accessible to people. But the pharmacy doesn't always manage its services effectively. The pharmacy delivers medicines to people without adequate controls and audit trails in place. And it doesn't adequately assess the risks of posting medicines or leaving them unattended at people's homes. Pharmacy team members take steps to identify people taking some high-risk medicines. And, they provide people with advice. But they don't have the required written information for people to take away. The pharmacy sources its medicines from reputable suppliers. But it doesn't always store and manage its medicines appropriately. There is evidence of out-of-date medicines in stock. And medicines stored outside the manufacturer's original packaging inappropriately. So, there is a risk the medicines are not safe to supply to people.

Inspector's evidence

The pharmacy had ramped access from the street to improve access to the premises. To help people access the pharmacy's services, pharmacy team members explained they would use written communication with someone with a hearing impairment. But they were unsure about how they would help someone with a visual impairment. Pharmacy team members spoke various other languages besides English that were spoken in the local community. These included Urdu, Punjabi and Hindi. They explained this was particularly useful because they had a high volume of elderly Asian patients who could not speak English.

Pharmacy team members signed the dispensed by and checked by boxes on dispensing labels. This was to maintain an audit trail of staff involved in the dispensing process. The pharmacy team used dispensing baskets throughout the dispensing process to help prevent prescriptions being mixed up. The pharmacist was aware of the risks for people taking valproate during pregnancy. And he explained how he would provide them with information. He did not ask them if they were enrolled in a pregnancy prevention programme. But he would ask them if they were using suitable contraception. The pharmacy had no printed information to give to people to educate them about the risks.

The pharmacy supplied medicines in multi-compartment compliance packs when requested. The pharmacy attached backing sheets to the pack, so people had written instructions of how to take the medicines. But these did not include descriptions of what the medicines looked like, so they could be identified in the pack. Pharmacy team members did not routinely provide people with patient information leaflets about their medicines. And, they did not keep a documented audit trail of any changes to medicines provided in packs. The pharmacy's documented procedure for the preparation of packs instructed pharmacy team members to maintain a record of any changes made. And to supply people with information leaflets about their medicines with each pack. So, pharmacy team members were not following the documented procedure. The pharmacy delivered medicines to people. But, it did not keep any records of the deliveries made. And, people were not asked to sign to confirm they had received their medicines. The delivery driver left a card through the letterbox if someone was not at home when they delivered. The card asked people to contact the pharmacy to arrange a re-delivery. The SI said that sometimes, the delivery driver posted medicines through the people's door. But they only did this if the pharmacy had been asked to do so. And, he said the person was always asked if there were any children or pets that may be able to access the medicines if posted. The pharmacy did not keep any records of when these questions had been asked or risk assessments to make sure posting

medicines was safe or appropriate.

The pharmacy obtained medicines from six licensed wholesalers. It stored medicines tidily on shelves. And all stock was kept in restricted areas of the premises where necessary. But the inspector found several packs on shelves that contained mixed batches and expiry dates. Some foil strips had been cut, so they no longer displayed a batch number or expiry date. And, some packs contained medicines that had been removed from their original blister packaging and had been placed back in to the boxes loose. There was no way to know if these had the same expiry and batch number as indicated by the outer packaging. And, as the medication hadn't been stored in accordance with the manufacturer's instructions, the team wouldn't know if these medicines were suitable to use. The pharmacy had adequate disposal facilities available for unwanted medicines, including controlled drugs (CDs). Pharmacy team members kept the CD cabinet(s) tidy and well organised. And, out of date and patient returned CDs were segregated. The inspector checked the physical stock against the register running balance for three products. And they were found to be correct. The pharmacy did not have any systems, software or equipment in place to comply with the Falsified Medicines Directive (FMD). Pharmacy team members had not been trained. But, they were aware of the new legal requirements. The SI said he was currently having discussions with his software providers and planned to implement a system as soon as possible.

Pharmacy team members checked medicine expiry dates every 12 weeks. And they sometimes recorded their checks. But the pharmacy did not have a record of any checks being completed after July 2019. The SI said that checks had been completed since but had not been recorded. The inspector found two boxes of oxycodone 20mg tablets in the CD cabinet that were out of date. One had expired in June 2019, and one in September 2019. And they were not highlighted as being short-dated. The packs were stored with in date stock. And, they had not been segregated like other out-of-date controlled drugs in the cabinet. Pharmacy team members highlighted any short-dated items with a sticker on the pack up to four months in advance of their expiry. And the process was to remove items expiring before the next date check. The pharmacy responded to drug alerts and recalls. And, any affected stock found was quarantined for destruction or return to the wholesaler. But they did not record the action they had taken. The pharmacy team kept the contents of the pharmacy fridge tidy and well organised. They monitored minimum and maximum temperatures in the fridge every day. And they recorded their findings. The temperature records seen were within acceptable limits.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the necessary equipment available, which it properly maintains. And, it manages and uses the equipment in ways that protect confidentiality.

Inspector's evidence

The pharmacy had the equipment it needed to provide the services offered. The resources available included the British National Formulary (BNF), the BNF for Children, various pharmacy reference texts and use of the internet. The pharmacy had a set of clean, well maintained measures available for medicines preparation. It kept sensitive information and materials in restricted areas. It positioned computer terminals away from public view. And, these were password protected. The pharmacy stored medicines waiting to be collected in the dispensary, also away from public view. And, it had a shredder available to destroy confidential waste.

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.