General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Riverside Pharmacy, Bulwell Riverside Centre, Main Street, Bulwell, NOTTINGHAM, NG6 8QN

Pharmacy reference: 1111449

Type of pharmacy: Community

Date of inspection: 11/12/2019

Pharmacy context

This is a community pharmacy attached to the surgery in Bulwell. Most of the activity is dispensing NHS prescriptions and giving advice about medicines over the counter. The pharmacy supplies medicines in multi-compartment compliance packs to people who live in their own homes. Other services that the pharmacy provides include prescription deliveries to people's homes, Medicines Use Reviews (MUR) and New Medicine Service (NMS) checks.

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 fails to identify and manage the risks associated with the provision of its services. The pharmacy has not reviewed its written procedures since 2015 and the pharmacy team have not read them. The pharmacy's records that it must keep by law are not complete or accurate. And it does not check its CD stocks regularly. This means it may not be aware if mistakes have been made.
		1.6	Standard not met	The pharmacy's records that it must keep by law are not complete or accurate.
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 team sometimes leaves tablets in unsealed compliance packs. This could affect the quality of the medicines. Some controlled drugs are not stored in accordance with legal requirements. So there is more risk of them being lost or stolen. The pharmacy does not have a robust date-checking procedure. This could increase the chance that expired medicines are supplied to people.
		4.4	Standard not met	The pharmacy doesn't keep records of the actions it takes in response to safety recalls. It was unable to show that it takes the right actions to protect people's health and wellbeing.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

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

Summary findings

The pharmacy fails to identify and manage the risks associated with the provision of its services. The pharmacy has not reviewed its written procedures since 2015 and the pharmacy team have not read them. The pharmacy's records that it must keep by law are not complete or accurate. And it does not check its CD stocks regularly. This means it may not be aware if mistakes have been made. The pharmacy asks people for their views and acts on the issues raised. It knows how to protect vulnerable people. The pharmacy has some procedures to learn from its mistakes. But it doesn't record all its near misses. So, it could be missing opportunities to improve its services.

Inspector's evidence

The pharmacy had a set of Standard Operating Procedures (SOPs) that should have been reviewed in July 2015. They had not been signed to show they had been read by any member of staff working in the pharmacy including the pharmacy manager. The pharmacy manager said that SOPs were under review and additional SOPs were being written for new services they hoped to start. The SOPs didn't reflect the fact that the pharmacy had a pharmacy robot which picked the medicine and had been fitted in 2016. The fact that SOPs were out of date and didn't reflect changes such as the dispensing robot increased the risk of staff not following pharmacy procedures or complying with best practice.

The dispenser understood the questions she should ask to sell an over-the-counter medicine safely. She knew that most prescriptions were valid for six months and that prescriptions for controlled drugs (CDs) were valid for 28 days from the date on the prescription. She said that dispensed CDs that were kept on the shelves that required a signature were highlighted. But that CDs that didn't require a signature were not. This increased the risk of a CD prescription being supplied beyond its validity. The pharmacy manager said that she would start highlighting all CDs. The dispenser said that they texted people to tell them that their medicines were ready before putting them on the shelf.

The final check was carried out by the pharmacist. The pharmacy had procedures in place for managing errors, incidents and near misses. The pharmacist discussed the near miss with the member of the team at the time and the aim was to make a record in the near miss log. The near miss log was in the consultation room rather than on the dispensing bench which made it less accessible. There were a small number of near misses recorded. The pharmacist said that not all near misses were recorded but there were fewer near misses made because of reduced picking errors because the robot picked the medicine. The pharmacy manger said that she reviewed the near misses and discussed issues in the weekly meeting but didn't make a formal record.

The pharmacy had an up-to-date NHS patient group direction (PGD) for providing flu vaccinations. The PGD available was not signed to show that the pharmacists had read the guidance and would comply with it. The pharmacy manager said that she had stopped providing the service for this year because of staff shortages and problems obtaining adrenaline for anaphylactic shock.

The pharmacy failed to fully maintain all the appropriate records to support the safe delivery of pharmacy services. This included the responsible pharmacist (RP) log and the CD registers. The pharmacy regularly supplied a significant quantity of CDs but a random check of the recorded running

balance of a CD didn’t match the actual stock and CDs were not regularly audited. Date-expired stock and patient-returned CDs were clearly separated and awaited destruction. The pharmacy had a patient-returned CD register. Most patient-returned CDs had been recorded in the register, but one had not been recorded. The pharmacy manager said that she would make sure the entry was made.

There was a complaints procedure in place; there was a poster in the public area asking for feedback. The latest patient satisfaction survey was on NHS.UK. All the people who completed the survey were satisfied with the overall service provided. Customers had complained about delivery times and so the pharmacy had extended delivery times to make them more convenient. The professional indemnity insurance certificate was on display.

The pharmacy had an information governance policy. Computer terminals in the dispensary were positioned so that they couldn’t be seen by people using the pharmacy. Access to the electronic patient medication record (PMR) was password protected. Confidential waste was destroyed securely.

The pharmacist was aware of safeguarding requirements and had completed appropriate training. Local contact details were available if the pharmacy needed to raise any safeguarding concerns.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy's team members are mainly suitably trained for the roles they undertake. Team members work well together, and they can raise concerns if needed. The team members receive some support in keeping their skills and knowledge up to date.

Inspector's evidence

The pharmacy displayed the RP notice to show who the responsible pharmacist in charge of the pharmacy was. On arrival the RP notice showed the wrong pharmacist. There were several gaps in the RP log. This meant that that the record didn't clearly show for a number of days who had been the responsible pharmacist. The pharmacy manager said that she would investigate the gaps and make sure that the correct pharmacist was recorded.

During the inspection there were two pharmacist, three trained dispensers and a trainee dispenser. During the inspection the team struggled a little with the workload. Staff spent some time looking through prescriptions that were waiting checking or were waiting to be dispensed for people waiting at the counter. The pharmacist said that due to the time of year there was an increased number of prescriptions and one surgery was slightly behind on issuing prescriptions. The pharmacy manager said that the pharmacy had three experienced staff off on long term sickness. Although she had employed some new staff who had pharmacy experience, she said that this had an impact on the efficiency of the service.

One member of staff was taking longer to complete the dispensing assistant course than would be expected. The pharmacy manager said she would give her support to complete her course. Staff said that they were given informal training by the pharmacist. They had recently been given access to an on-line training portal but had not carried out any training because they hadn't had time because the pharmacy was too busy. Staff said they were able to raise issues and said that the pharmacist was easy to approach. They had staff meetings every Tuesday where issues could be raised or shared. The superintendent pharmacist did not set targets for services.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy keeps its premises safe, secure and mainly appropriately maintained. The pharmacy protects personal information. The premises are secure from unauthorised access during working hours and when closed

Inspector's evidence

The public area presented a smart appearance. During the inspection there was a regular beeping from this area. Staff said that this had been going on for several weeks. It was a low battery alarm and had been reported but not yet repaired. The pharmacy had an air conditioning system which provided a suitable temperature. Lighting was adequate for the pharmacy services offered.

The pharmacy had a dispensing robot which took up a large amount of the dispensary. This meant that the floor space in the dispensary and behind the medicines counter was minimal and difficult for members of staff to pass each other. There were stock and dispensed medicines in tote boxes which made the narrow dispensary even narrower and could create a trip hazard. But there was a separate area for dispensing multi-compartment compliance packs which was a good size. There were separate designated areas for the dispensing and checking of medicines. There was a private soundproof consultation room It was also used as a staff room. Prepared medicines were held securely within the pharmacy premises and pharmacy medicines were stored behind the medicines counter.

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

Summary findings

The pharmacy does not make sure its services are always delivered safely and effectively. The pharmacy team sometimes leaves tablets in unsealed compliance packs. This could affect the quality of the medicines. Some medicines are not kept in accordance with legal requirements. So there is more risk of them being lost or stolen.The pharmacy obtains its medicines and medical devices from reputable sources but it does not have a robust date-checking procedure. This could increase the chance that expired medicines are supplied to people. The pharmacy doesn't keep records of the actions it takes in response to safety recalls. It was unable to show that it takes the right actions to protect people's health and wellbeing.

Inspector's evidence

The pharmacy had step free access from the pavement and automatic front doors. A home delivery service was available for people that could not access the pharmacy. Opening hours and the services provided were displayed. The pharmacist had an understanding of signposting and was able to direct people to local health services. The pharmacy staff were able to communicate with people in a range of languages. This enabled pharmacy staff to communicate with members of the local community when their first language was not English.

One of the pharmacists was always easily accessible to people visiting the pharmacy. The pharmacist said that he gave advice to people about a range of issues. This included new medicines and changes in dose and interactions. He gave advice to people taking higher-risk medicines such as warfarin but didn't make a record. The pharmacist knew the advice about pregnancy prevention that should be given to people in the at-risk group that took sodium valproate. But the pharmacy didn't have any leaflets. The pharmacy manager said that she would contact the manufacturer and arrange to get some.

The pharmacy used a dispensing audit trail which included use of 'dispensed by' and 'checked by' boxes on the medicine label. This helped identify who had completed each task. Baskets were used to reduce the risk of error. The pharmacy had a defined workflow with separate areas for dispensing and checking of medicines. The pharmacy used a dispensing robot to dispense the majority of prescriptions medicines. The pharmacy manager explained how the robot worked and how it improved patient safety by reducing picking errors and improving efficiency. There were three fridges in place to hold stock medicines and assembled medicines. The medicines in the fridges were stored in an organised manner. Fridge temperature records were maintained.

The pharmacy manager explained the date checking process. The robot controlled the date checking for the stock inside. Stock was date checked before it went into the robot and was given a six-month or nine-month expiry date. The robot quarantined any stock after the expiry date was reached and would not dispense it. The pharmacy staff hadn't had a chance to check the quarantined stock in the robot since September 2019. Ninety items were highlighted as potentially out of date. Split boxes had been taken out from the robot around a month before the inspection because the robot struggled to recognise them. These were now on shelves in the dispensary. Stock on the shelves was stored untidily with different strengths of medicines on top of each other. The pharmacy manager said that stock on the shelves had been date checked when it was removed from the robot, but records weren't available during the inspection. In a short check of the split boxes several out-of-date medicines were found. The pharmacy manager said that she would arrange a date check. Some medicines had been popped into

brown bottles. These bottles had a label recording the medicine name. To reduce the risk of supplying an inappropriate medicine bottles should also record the original batch number and expiry date of the medicines and the date the medicines were put in the bottle. Some open bottles of liquids had the date of opening and the use by date recorded. A bottle with a use by date of October 2019 had not been removed from the shelf. Some bottles with a short expiry date when opened did not have the date of opening recorded.

Each person who received their medicine in a compliance pack had an individual record which listed their medicines and what time of day they should be taken. Compliance packs for people being sent their medicines weekly were assembled before the prescription was received. The pharmacy manager said that this was because of time pressures but that packs did have a final check and were not sent out without a prescription being received. She agreed to wait for the prescription before assembling the pack because she accepted that assembling without a prescription was less safe. The compliance packs were left unsealed when assembled but were not always checked the same day. This increased the risk of medicines moving from one compartment to another and the risk of degradation due to moisture or air etc. Some of the medicine administration record charts (MAR charts) recorded the shape and colour of the medicine to allow easy identification but some packs seen recorded the medicine as a ‘tablet or a ‘capsule’ which made identification less easy. Patient information leaflets were not always sent which meant that people may not always have the information they needed to take their medicines safely.

The pharmacy delivered medicines to some people. The person who received the medicine signed for the medicine to create an audit trail. Only recognised wholesalers were used for the supply of medicines. The pharmacy received drug alerts by emails. The pharmacy manager explained the process that was followed. The pharmacy did not create an audit trail to show what action had been done. The pharmacy manger had been away from the pharmacy for a few days and was not aware of the most recent alert for ranitidine which should have been completed within 48 hours. She didn’t know if any action had been taken. She said that she would have picked up the alert when she checked her emails. The pharmacy had Falsified Medicine Directive compliant scanners in place and the computer had the software capability, but they had not started implementing the process.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy mainly has access to the appropriate equipment and facilities to provide the services that it offers. It largely adequately maintains its equipment and facilities.

Inspector's evidence

The pharmacy used crown-marked measures for measuring liquids. The pharmacy had up-to-date reference sources. Records showed that the fridge stored medicines were correctly between 2 and 8 degrees Celsius. CD cupboards complied with legal requirements. The pharmacy had a maintenance contract for the dispensing robot.

Records showed that portable electrical equipment had last been tested for safety in February 2018. The pharmacy manager said that she would raise the issue with the superintendent.

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.