General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Elloughton Pharmacy, 63 Main Street, Elloughton, BROUGH, North Humberside, HU15 1HU

Pharmacy reference: 1115429

Type of pharmacy: Community

Date of inspection: 21/11/2019

Pharmacy context

This community pharmacy is in the large village of Ellougton. The pharmacy dispenses NHS and private prescriptions. The pharmacy supplies multi-compartment compliance packs to help people take their medicines. And it delivers medication to people's homes. The pharmacy provides the supervised methadone consumption service.

Overall inspection outcome

✔ **Standards met**

Required Action: None

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	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 identifies and manages the risks associated with the delivery of its pharmacy services. The team members have training, guidance and experience to respond to safeguarding concerns. So, they can help protect the welfare of children and vulnerable adults. The pharmacy team members record and discuss errors that happen whilst dispensing. And they respond appropriately. As they make changes to the way they work to reduce the risk of similar errors happening. The pharmacy has arrangements to protect people's private information. And people using the pharmacy can raise concerns and provide feedback. The pharmacy keeps most of the records it needs to by law.

Inspector's evidence

The pharmacy had a range of standard operating procedures (SOPs). These provided the team with information to perform tasks supporting the delivery of services. The SOPs covered areas such as dispensing prescriptions and controlled drugs (CDs) management. The team had read the SOPs and signed the SOPs signature sheets to show they understood and would follow them. The SOPs had review dates of June 2019, but the Superintendent Pharmacist had not completed the review. The pharmacy had up-to-date indemnity insurance.

On most occasions the pharmacist when checking prescriptions and spotting an error asked the team member involved to find and correct the mistake. The pharmacy kept records of these near miss errors. The team member involved completed the record. A sample of the near miss error records looked at found that the team members recorded details of what had been prescribed and dispensed to spot patterns. And they completed the sections to record their learning from the error and actions they had taken to prevent the error happening again. But the descriptions in these sections of the record were the same for each entry. The details recorded were 'check the dose' for the learning points section. And 'double check' for all the action points. So, there was little evidence of individual reflection and learning. The pharmacist reviewed these records each month to spot patterns and make changes to processes. And shared the results with the team. The team had separated products that looked alike and sounded alike (LASA) such as amitriptyline and amlodipine. The pharmacy team recorded dispensing incidents. These were errors identified after the person had received their medicines. The team also captured the dispensing incident on to the person's electronic medication record (PMR). So, all the team were aware of the error. And to help prevent the error happening again to the same person. Following a recent error when a person was supplied the wrong medicine, the team recorded the error and separated the two products. The pharmacist made all team members aware of the error. And asked them to not disturb the pharmacists when they were checking prescriptions. The pharmacist manager attached the empty container with the dispensing label on to the wall by the pharmacist checking area, to remind the team of this error.

The pharmacy had a procedure for handling complaints raised by people using the pharmacy. And it had a poster providing people with information on how to raise a concern. The pharmacy team used surveys to find out what people thought about the pharmacy. The pharmacy published these on the NHS.uk website. The pharmacists shared comments left by people on the NHS.uk website with the team.

A sample of controlled drugs (CD) registers looked at found they met legal requirements. The pharmacy did not regularly check all the CD stock against the balance in the register. So, the team did not have

information to spot errors such as missed entries. A random balance check of a CD found it matched the quantity in the CD register. The pharmacy had a book to record CDs returned by people. A sample of Responsible Pharmacist records looked at found that they met legal requirements. The records of private prescription supplies looked at found that the prescriber's details were either missing or not always correct. A sample of records for the receipt and supply of unlicensed products looked at found that they did not meet the requirements of the Medicines and Healthcare products Regulatory Agency (MHRA). The team had not received training on the General Data Protection Regulations (GDPR). The pharmacy displayed details on the confidential data kept and how it complied with legal requirements. But it did not display a privacy notice in line with the requirements of the GDPR. The team separated confidential waste for shredding onsite.

The pharmacy had a safeguarding SOP signed by the team to confirm it had been read. And the team members had access to contact numbers for local safeguarding teams. The pharmacists had completed level 2 training in 2017 from the Centre for Pharmacy Postgraduate Education (CPPE) on protecting children and vulnerable adults. The team had completed Dementia Friends training. The team responded well when safeguarding concerns arose. One of the regular pharmacists delivered medicines to people's homes. And reported to the GP teams any concerns they had about people they delivered to. Two of the dispensers had previously worked in a care home. So, they had received safeguarding training and recognised the signs of dementia.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy team members have the qualifications and skills to provide the pharmacy's services. And they support each other in their day-to-day work. The team members discuss and share ideas. They identify improvements to the delivery of pharmacy services. And they introduce processes to improve their efficiency and safety in the way they work. The team members share information and learning particularly from errors when dispensing. And some team members have opportunities to complete ongoing training. The team members don't receive formal feedback on their performance. So, they may miss the opportunity to improve and identify new roles to help the safe and effective delivery of services.

Inspector's evidence

Two full-time pharmacists and the Superintendent Pharmacist covered most of the opening hours. The two full-time pharmacists worked together each week day. And one of them was the pharmacy manager. The pharmacy team consisted of two full-time dispensers and a part-time dispenser. On the day of the inspection the two full-time pharmacists and the three dispensers were on duty. Two of the dispensers had previously worked in a care home so had experience with medicines.

The pharmacy held regular team meetings. The pharmacists had identified several training courses provided by the NHS that would meet gaps in their knowledge and skills. And with support from the Superintendent Pharmacist the two pharmacists had completed the courses. The pharmacists often travelled distances to attend CPPE training events as courses were rarely held in the local area. The pharmacy did not offer extra training for the rest of the team. And it did not provide performance reviews for the team members. So, they did not have a chance to receive feedback and discuss development needs. The team received informal feedback as and when it was required.

The pharmacy had a whistleblowing procedure providing the team with information on how to raise a concern. Team members could suggest changes to processes or new ideas of working. The team had changed the process for handling incomplete prescriptions. The team put dispensed items from the prescription in to a bag. And attached the dispensing label for the outstanding item to the bag. So, when the stock arrived from the wholesaler the team gave priority to dispensing these items. The label was also a prompt for the pharmacist to check the missing items were on the wholesaler's order before it was sent at the end of the day. The pharmacy did not set targets for services such as Medicine Use Reviews (MURs). The pharmacists offered these services when they would benefit people.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean, secure and suitable for the services provided. And it has facilities to meet the needs of people requiring privacy when using the pharmacy services.

Inspector's evidence

The pharmacy was clean, tidy and hygienic. It had separate sinks for the preparation of medicines and hand washing. The team members used disposable gloves when dispensing medicines in to the multi-compartment compliance packs. The pharmacy had enough storage space for stock, assembled medicines and medical devices.

The pharmacy had a sound proof consultation room. The team used this for private conversations with people. The premises were secure. The pharmacy had restricted access to the dispensary during the opening hours. The window displays detailed the opening times and the services offered. The pharmacy had a defined professional area. And items for sale in this area were healthcare related.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy team provides services that support people's health needs. And it manages its services well. The team works closely with members of other healthcare teams. To help support the safe and effective delivery of services. The pharmacy keeps records of prescription requests and deliveries it makes to people's home. So, it can efficiently deal with any queries. The pharmacy obtains its medicines from reputable sources. And it mostly stores and manages medicines appropriately.

Inspector's evidence

People entered the pharmacy via a small step with a handrail. The team had access to the internet to direct people to other healthcare services. The pharmacy kept a small range of healthcare information leaflets for people to read or take away. And it had a monthly healthcare leaflet providing people with information on a particular medical condition. The leaflet included a quiz to test the person's knowledge on the information provided. Recent topics included Stoptober and minor ailments. The leaflet also included the pharmacy opening hours and contact details. The two regular pharmacists had a good working relationship with the team at the GP local surgery. And regularly met with the GPs and the practice-based pharmacist.

The pharmacy provided multi-compartment compliance packs to help around 30 people take their medicines. People received monthly or weekly supplies depending on their needs. One of the full-time pharmacists managed the service. And got support from the dispensers in the team. To manage the workload the team divided the preparation of the packs across the month. The team ordered the prescriptions in time to deal with issues such as missing medicines. And to allow time for dispensing the medication in to the packs. The pharmacist was working with the pharmacist at the GP surgery to enable the team to prepare the packs in advance for the Christmas period. Each person had a record listing their current medication and dose times. The team checked received prescriptions against the list. And queried any changes with the GP team. The team used an upstairs room to dispense and check the packs. This was away from the distractions of the retail area. The team had converted this room to accommodate an increase in the number of packs. The team recorded the descriptions of the products within the packs. And it supplied the manufacturer's patient information leaflets. The team used shelves labelled with the days of the week to store completed packs. The pharmacy did not receive copies of hospital discharge summaries. Often the team only knew of the person's discharge and any medicine changes when the person or their representative informed the pharmacy team. After receiving this information, the pharmacist passed it on to the GP team. And asked for new prescriptions when required. These prescriptions often arrived late at the pharmacy, close to the time the person needed their medicines. So, the team had little time to prepare the new packs. The pharmacist was liaising with the GP team and practice-based pharmacist to address this matter.

The pharmacy supplied methadone as supervised and unsupervised doses. And it prepared the methadone doses in advance before supply. This reduced the workload pressure of dispensing at the time of supply. The pharmacy stored the prepared doses in the controlled drugs cabinet in the same basket. So, there was no separation between people's doses to reduce the risk of selecting the wrong one. The team members provided a repeat prescription ordering service. The team asked people to mark the repeat prescription slip with the medicines they wanted for the next supply. The team usually

ordered the prescriptions a few days before supply. This gave time to chase up missing prescriptions, order stock and dispense the prescription. The team members kept a record of the prescription request. And they regularly checked the record to identify missing prescriptions to chase them up with the GP teams. The team passed on information to people from their GP such as the need to attend the surgery for a medication review. This included highlighting the information when it appeared on the repeat prescription slip. The pharmacy team was aware of the criteria of the valproate Pregnancy Prevention Programme (PPP). The pharmacy had the PPP pack to provide people with information when required. The team asked people prescribed high-risk medicines for instance warfarin if they had information such as latest blood tests and doses. But the team did not make a record when the person provided this information.

The pharmacy provided separate areas for labelling, dispensing and checking of prescriptions. The pharmacy team used baskets when dispensing to hold stock, prescriptions and dispensing labels. This prevented the loss of items and stock for one prescription mixing with another. The team members referred to the prescription when selecting medication from the storage shelves. This acted as a prompt for the team to check the product they had picked. The pharmacy used CD and fridge stickers on bags and prescriptions to remind the team when handing over medication to include these items. The pharmacy had a system to prompt the team to check that supplies of CDs prescriptions were within the 28-day legal limit. The pharmacy had checked by and dispensed by boxes on dispensing labels. These recorded who in the team had dispensed and checked the prescription. A sample looked at found that the team completed the boxes. When the pharmacy didn't have enough stock of someone's medicine, it provided a printed slip detailing the owed item. And kept a separate one with the original prescription to refer to when dispensing and checking the remaining quantity. The pharmacy kept a record of the delivery of medicines to people. This included a signature from the person receiving the medication. The pharmacy obtained separate signatures for CD deliveries. One of the pharmacists provided the delivery service. So, they could help people with their queries at the point of handing over their medicine.

Several loose strips of medicines were found on the shelves. Most were complete strips so information such as batch number and expiry date was available. The pharmacy team checked the expiry dates on stock. But it did not keep a record of this. The team used coloured dots to highlight medicines with a short expiry date. And liaised with the pharmacists when dispensing to check if a medicine with a short expiry date could be given out. The team informed the person receiving the medicine of the short expiry date. No out of date stock was found. The team members did not always record the date of opening on liquids. This meant they may not identify products with a short shelf life once opened. And check they were safe to supply. The team recorded fridge temperatures each day. A sample looked at found they were within the correct range. The pharmacy had medicinal waste bins to store out-of-date stock and patient returned medication. And it stored out-of-date and patient returned controlled drugs (CDs) separate from in-date stock in a CD cabinet that met legal requirements. The team used appropriate denaturing kits to destroy CDs.

The pharmacy had no procedures or equipment to meet the requirements of the Falsified Medicines Directive (FMD). And the team did not know when the pharmacy would receive the equipment and computer software to comply with FMD. The pharmacy obtained medication from several reputable sources. And received alerts about medicines and medical devices from the Medicines and Healthcare products Regulatory Agency (MHRA) via email. The team usually printed off the alert, actioned it and kept a record.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide safe services and protect people's private information.

Inspector's evidence

The pharmacy had references sources and access to the internet to provide the team with up-to-date clinical information. The pharmacy used a range of CE equipment to accurately measure liquid medication. And used separate, marked measures for methadone. The pharmacy had a fridge to store medicines kept at these temperatures. The fridge was full of completed prescriptions awaiting collection. This means there is a risk of inefficient air flow helping to keep the fridge at the correct temperature.

The computers were password protected and access to people's records restricted by the NHS smart card system. The pharmacy positioned the dispensary computers in a way to prevent disclosure of confidential information. The pharmacy stored completed prescriptions away from public view. And it held private information in the dispensary and rear areas, which had restricted access. The team used cordless telephones to make sure telephone conversations were held in private.

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.