General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Grimsargh Pharmacy, 136 Preston Road, Grimsargh, PRESTON, PR2 5JQ

Pharmacy reference: 1115613

Type of pharmacy: Community

Date of inspection: 15/07/2019

Pharmacy context

This is a community pharmacy located on small parade of shops. It is situated in the village of Grimsargh, north east of Preston. 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 minor ailment service. A number of people receive their medicines in multi-compartment compliance aids.

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 follows written procedures, and this helps to maintain the safety and effectiveness of the pharmacy's services. The pharmacy keeps the records it needs to by law. People who work in the pharmacy receive training about the safe handling and storage of data. This helps to make sure that they know how to keep private information safe. Members of the pharmacy team do not always make records of things that go wrong. So they may miss opportunities to learn from them and prevent the same mistakes happening again.

Inspector's evidence

There was a current set of standard operating procedures (SOPs), which had a stated date of review of February 2020. The pharmacy team had signed to say they had read and accepted the SOPs.

The pharmacist said he would record dispensing errors on a standardised form and investigate the error. He said he would record the details about the investigation in the communications diary and share it with the rest of the pharmacy team. There weren't any recent records of errors.

A paper log was available to record near miss errors. The last error was recorded 12 months ago. The pharmacist said some near miss errors had occurred but not been recorded on the log. He said when he discovered an error, he would discuss it with the pharmacy team and segregate stock if appropriate. For example, simvastatin 10mg and 20mg tablets had been moved away from the 40mg tablets due to common picking errors.

Roles and responsibilities of the pharmacy team were described in individual SOPs. The pre-registration pharmacist (pre-reg) 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. But details about it were not on display so people may not always know how they can raise concerns. Complaints were recorded to be followed up by the superintendent (SI).

A current certificate of professional indemnity insurance was on display in the pharmacy. Records for the RP, private prescriptions, emergency supplies and unlicensed specials appeared to be in order. Controlled drugs (CDs) registers were maintained with running balances recorded. The balances of two random CDS were checked and both found to be accurate. Patient returned CDs were recorded in a separate register.

An information governance (IG) policy was available. The pharmacy team had completed GDPR training and had signed confidentiality agreements. When questioned, the pre-reg was able to describe what confidential waste was and how it was segregated into a separate bag for disposal by a waste carrier. A privacy notice was displayed and provided information about how the company handled people's data.

Safeguarding procedures were included in the SOPs and had been read by the pharmacy team. The pharmacist said he had completed level 2 safeguarding training. Contact details of the local

safeguarding board were available. The pre-reg 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 – who was the superintendent (SI), a pre-registration pharmacist (pre-reg), a dispenser and two delivery drivers. All members of the team had completed the necessary training for their roles.

The normal staffing level was a pharmacist and two dispensary staff.
The volume of work appeared to be managed. Staff's holidays were staggered so that only one planned absence occurred at a time. The pharmacist said if there were a number of staff absent, he would arrange for a locum pharmacist to work alongside him. The pre-reg was due to leave in four weeks' time, and the company were in the process of recruiting a dispenser.

The company provided the pharmacy team with some additional learning, for example they had recently completed a training pack about Dementia friends and healthy living pharmacy. Staff were allowed learning time to complete training. But further learning was not provided in a structured or consistent manner. So learning needs may not always be fully addressed.

The pre-reg 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 he felt able to exercise his professional judgement and this was respected by the pharmacy team and the company. The pre-reg said she received a good level of support from the pharmacist and felt able to ask for further help if she needed it. Appraisals were conducted annually by the SI.

The staff held weekly huddles about issues that had arisen, including when there were 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 whistleblowing policy and said that they would be comfortable reporting any concerns to the SI. Targets for services were not set by the company.

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 tidy, and appeared adequately maintained. 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 heaters and fans. 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. The space was clutter free with a computer, desk, seating, adequate lighting, and a wash basin. 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 via a single door and was suitable for wheelchair users. There was wheelchair access to the consultation room. Various posters provided information about the services offered. Pharmacy staff were able to list and explain the services provided by the pharmacy. The pharmacy opening hours were displayed at the entrance of the pharmacy and a range of leaflets provided information about various healthcare topics.

There were local restrictions in the area which prevented the pharmacy from ordering prescriptions on behalf of people. The pharmacy had a delivery service. Deliveries were segregated after their accuracy check and a sheet was used to obtain signatures from the recipient to confirm delivery. Unsuccessful deliveries would be returned to the pharmacy and a card posted through the letterbox indicating the pharmacy had attempted a delivery. The delivery driver sometimes posted medicines through letter boxes. This only happened if the patient had given permission and following a verbal risk assessment, but the pharmacy did not always check to make sure circumstances had not changed. This means the pharmacy could not show that it was safe to leave medicines in this way. CDs were recorded on a separate delivery sheet for individual patients and a separate signature was obtained to confirm receipt.

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.

Dispensed medicines awaiting collection were segregated away from the dispensing area on a collection shelf using an alphabetical retrieval system. Prescription forms were not always retained. So the pharmacy team may not have all of the information they may need when medicines are handed out. 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 CDs were highlighted so that staff could check prescription validity at the time of supply. However; schedule 4 CDs were not. So there is a risk that these medicines could be supplied after the prescription had expired. 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 he 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 compliance aids. A record sheet was kept for all compliance aid patients, containing details of current medication. Any medication changes were confirmed with the GP surgery before the record sheet was amended. Hospital discharge information was sought. Disposable equipment was used to provide the service, and the compliance aids were labelled with dispensing check audit trail. But compliance aids 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.

The pharmacy offered blistered medication to care homes. A re-order sheet was provided to the pharmacy and it contained details about the medicines required, medicine changes and any handover notes for the pharmacy. When prescriptions were received from the GP surgery they would be compared to the re-order sheet to confirm all medicines were received back. Any queries were chased up with the GP surgery and the care home was informed. Medicines were dispensed into disposable compliance aids and a dispensing and checking signature was written onto the label. A delivery sheet was used and signed by the care home.

Medicines were obtained from licensed wholesalers, with unlicensed medicines sourced from a specials manufacturer. The pharmacy was not yet meeting the safety features of the Falsified Medicines Directive (FMD), which is now a legal requirement. The pharmacy had signed up to a provider and obtained equipment. But due to difficulties experienced with the provider, they had returned the equipment and signed up with a new company. New equipment had been ordered and were due to be delivered.

Stock was date checked on a three month rotating cycle. 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 rubber band and liquid medication generally had the date of opening written on.

Controlled drugs were stored appropriately in the CD cabinet, with clear segregation between current stock, patient returns and out of date stock. 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 three months. Patient returned medication was disposed of in designated bins for storing waste medicines located away from the dispensary.

Drug alerts were received electronically by email. Alerts were printed, action taken was written on, initialled and signed before being filed in a folder.

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 May 2019. There was a selection of liquid measures with British Standard and Crown marks. The pharmacy also had equipment for counting loose tablets and capsules, including tablet triangles, a capsule counter and 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.

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.