General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Cowplain Pharmacy, 26-30 London Road, Cowplain, WATERLOOVILLE, Hampshire, PO8 8DL

Pharmacy reference: 1115950

Type of pharmacy: Community

Date of inspection: 21/08/2019

Pharmacy context

This is an independently owned community pharmacy, joined to the medical centre next door. It is one of two owned by the same company. The pharmacy is in the village of Cowplain, on the outskirts of Waterlooville, and offers an extended-hours dispensing service. As well as NHS essential services the pharmacy provides medicines in multi-compartment compliance packs for many people in the community and in nursing homes. Other services include: Medicines Use Reviews (MURs), New Medicines Service (NMS) and a delivery service for the elderly and housebound.

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	1.2	Standard not met	The pharmacy team does not do not do enough to gather information in a way that will help it review what has gone wrong so that it can learn and improve.
		1.3	Standard not met	The pharmacy does not do enough to ensure that team members are clear about their roles and responsibilities. Some team members are not allways clear about when they should refer to more appropriately skilled members of the team.
		1.6	Standard not met	The pharmacy does not keep all of its records in the way the law requires.
2. Staff	Standards not all met	2.2	Standard not met	less experienced team members are not provided with enough training and support to develop their skills and carry out their tasks effectively.
3. Premises	Standards met	N/A	N/A	N/A
4. Services, including medicines management	Standards not all met	4.2	Standard not met	Team members do not always give people the advice and information they need to help them use their medicines safely and properly. The pharmacy does not do enough to ensure that its team members follow procedures which are safe and effective.
		4.3	Standard not met	The pharmacy doesn't carry out all of its checks as thoroughly as it could. And, it does not always properly label medicines which are not in their original packs.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

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

Summary findings

In general, the pharmacy's working practices are safe and effective. Its team members listen to people's concerns and keep people's information safe. They discuss any mistakes they make and share information on what could go wrong to help reduce the chance of making mistakes in future. But they do not do enough in the way that they gather information and use it to learn and improve. Team members have a general understanding of their job roles, but some team members are not always clear about when they should refer to more appropriately skilled members of the team. The pharmacy does not do enough to ensure that team members have the right training and support to carry out their tasks. The pharmacy does not keep all of its records in the way the law requires.

Inspector's evidence

While the pharmacy had a procedure for managing risks in the dispensing process, it wasn't followed. According to the procedure, all incidents, including near misses were to be recorded and discussed, but the last recorded near miss was April 2019, over four months earlier. Without accurate records of what had gone wrong it may be difficult for the pharmacists and staff to conduct a thorough review of their mistakes so that they could learn from them.

The pharmacy had a 100-hour contract, and so, within those hours, it offered a dispensing service round the clock from 8 o'clock on Monday morning until 8pm on Thursday night. It also had an extended hours service on Friday. But, the near misses which had been recorded several months before did not show the times of the incidents. This information would be relevant in a pharmacy where levels of activity and staff numbers fluctuated over a 24-hour period. Previous near miss records indicated that mistakes had occurred because of staff rushing or misreading the prescription. As a follow up staff were required to 'double check' what they had dispensed. But the same causes and follow up actions had been repeated on many occasions, indicating that a more thorough analysis and response may be required for each incident. Near miss incidents had not prompted a review of the team's compliance with a robust dispensing procedure or caused team members to reflect on their own dispensing technique to identify any steps which could have prevented the error. Nor had the team considered any wider contributory factors. When on duty on his own the pharmacist said he always took a break between dispensing and checking prescriptions.

However, it was clear that the team discussed any incidents and were aware of the risk of error. The pre-reg pointed out two different pack sizes of indapamide 2.5mg which looked identical apart from the tablet number printed on each pack. All team members had been made aware of the similarity. A warning sticker had been placed on the shelf edge in front of the tablets, prompting team members to check the pack size each time they dispensed them. Shelf edge stickers had also been placed on shelf edges in front of less frequently prescribed items such as salbutamol easi-breathe inhaler and in front of ropinirole SR tablets and ropinirole MR tablets. The team had also separated packs of sertraline from sildenafil tablets, and packs of bendroflumethiazide tablets from bisoprolol tablets because of their similar names and strengths. These measures had been taken to help prevent staff from picking the wrong packs.

Team members worked under the supervision of the responsible pharmacist (RP). But, the RP had not displayed the notice with his registration details for the public to see. But, he was able to produce the notice and put it on display when requested. The team had a set of standard operating procedures (SOPs) to refer to. But, not all team members had read SOPs relevant to their roles. Including the pre-reg who had been dispensing since she began her training two weeks earlier. It was unclear as to whether staff fully understood their roles.

The pharmacy team had a positive approach to customer feedback. The dispenser manager described how they had employed more staff following a concern about waiting times. They had also improved communications with their customers to help manage expectations. Team members on the counter were now more likely to explain that larger prescriptions would take longer to dispense and that the waiting time may be longer when they were busy. The team described how they ordered the same brands of medicines for people to help with compliance. Individual preferences included Teva or Almus brands of various medicines and the Adcal-D3 brand of calcium carbonate effervescent tablets. Another patient, who was allergic to certain colourings, preferred the Wockhardt brand of atenolol as it didn't contain the colouring present in a number of other brands. Notes had been added to the relevant patient medication records (PMRs) and details were printed on patients' labels as an additional prompt for the team. But, team members said that, in general, they tried to keep to ordering the same brands to help patients have confidence in their medicines, although, shortages of some brands meant that this was not always possible.

The pharmacy had a complaints' handling procedure. Complaints and dispensing incidents were recorded. Customer concerns were generally dealt with at the time and recorded for the attention of the superintendent. Details of the local NHS complaints advocacy service and PALs could be provided on request. The pharmacy had professional indemnity and public liability arrangements, so they could provide insurance protection for staff and customers. Insurance arrangements were in place until 30th November 2019 when they would be renewed for the following
year.

The pharmacy had systems for keeping all the necessary records but not all records were accurate or in order. The pharmacy had a system for recording patient returned CDs. Records of returned CDs are necessary for audit trail and to account for all the non-stock CDs which RPs have under their control. Records of emergency supplies were generally in order although did not always give a clear reason for the decision to supply. Records for private prescriptions, unlicensed 'Specials' and the responsible pharmacist were all in order and up to date.

Staff understood the importance of safeguarding people's private information and had been briefed as part of their induction when they joined the team. Discarded labels and prescription tokens were collected for safe disposal by a licensed waste contractor. Regular pharmacists, the dispenser and the trainee technician manager had all completed level 2 CPPE safeguarding training and remaining staff had completed training through NPA or been briefed by senior staff.

Principle 2 - Staffing **Standards not all met**

Summary findings

The pharmacy team generally manages the workload safely and effectively and team members work together. They are comfortable about providing feedback to employers and are involved in improving the pharmacy's services. But, less experienced team members are not provided with enough training and support to develop their skills and carry out their tasks effectively. And the pharmacy may not have enough staff when providing services out of hours.

Inspector's evidence

In general, pharmacy services were covered by two regular locum RPs and the superintendent (SI) who attended the pharmacy from time to time to provide additional support. The rest of the team consisted of a pre-registration pharmacist (pre-reg) of two weeks, a full-time trainee technician and manager, a full-time dispenser, a part-time dispenser, a part-time trainee dispenser, a medicines counter assistant (MCA) and a counter assistant who was on placement for her pharmaceutical sciences degree. Both the trainee dispenser and the student counter assistant had yet to be enrolled on an appropriate pharmacy training course. The MCA, was observed to assist with dispensing but she too, had not been enrolled on a dispensing course.

For the first hour of the inspection (8am to 9am) the locum RP was on his own but was observed to be very busy with customers waiting for up to ten minutes to be seen while he dispensed prescriptions. The phone also had to be left unanswered while he dispensed. He informed the inspector that he was often that busy at that time in the morning when on his own. At 9am he changed shifts with the second locum RP who was due to work until 8pm. The first locum would return at 8pm to cover the overnight shift until 9am the next morning. This shift pattern ran from 8am on a Monday morning until 8pm on a Thursday night when the pharmacy closed overnight. The pharmacy re-opened 8am until 8pm on Friday and 7am until 1pm on Saturday. At the time of the inspection the pharmacy team consisted of one of the regular RPs, the pre-reg pharmacist, the trainee technician manager, two dispensers, a trainee dispenser and the student counter assistant. The MCA arrived part way through the inspection.

The inspection took place when the pharmacy was busy. But, the team was up to date with the daily workload of prescriptions and customers were attended to promptly. The dispenser said she felt supported in her role and could raise concerns. She described having regular informal discussions with the team including the manager and SI and between them they would discuss how things could be improved. She said she had suggested that the pharmacy be provided with an additional computer to ease workflow particularly when the team expected there to be an increase in work when scanning products in accordance with the new falsified Medicines Directive (FMD). The SI and manager accepted that they needed an additional computer, but it had yet to be installed.

The locum pharmacist was not set targets for Medicines Use Reviews (MUR)s. She said that as a team they tried to offer an MUR to everyone who needed one. She said she was able to provide MURs for people who needed one without compromising attention to the remaining workload. She aimed to provide a good service by ensuring that people's medicines were dispensed on time and the day's

workload completed. She described providing many MURs to people who needed advice with their inhaler technique. Many of whom also benefitted from an explanation on the actions and uses of their different types of inhaler.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy's premises are clean and professional looking. They provide a safe, secure environment for people to receive healthcare services. But storage arrangements meant that it did not look as tidy and organised as it could.

Inspector's evidence

The pharmacy was attached to a health centre. The pharmacy had its own external entrance. But internally, it had a shared connecting doorway with the medical centre, so patients could pass between the two without going outside. The double doors between the medical centre and the pharmacy were kept open during normal business hours. But, when the medical centre was closed and the pharmacy open (and vice versa) the doors were closed and locked. The pharmacy also had a dispensing hatch which allowed the pharmacist to take in prescriptions and hand out medicines after 8pm when the rest of the pharmacy was closed.

The pharmacy had a bright modern appearance and customer areas were generally clean and tidy. It had a spacious shop floor and a consultation room for private consultations such as MURs. The pharmacy had a staffroom and toilet which were accessed from the shop floor. Staff toilet facilities were clean with hand washing facilities. The pharmacy had an elongated layout. The dispensary was situated alongside the counter and staff could access it easily from the counter. The pharmacy had a spacious dispensary. It had an L-shaped dispensing bench on two sides with open shelves, for storing stock, above and below. There was a clear work flow with clearly defined areas for dispensing and accuracy checking and for making up multi-compartment compliance packs. The main dispensary work surface was close to the counter and shop floor, allowing the pharmacist to counsel people and help them at the counter when necessary.

But, storage in the dispensary appeared to be inadequate. Bulky prescriptions were stored in several tote boxes on the floor, as were multi-compartment compliance packs. Prescription baskets containing incomplete prescriptions had also been placed on the floor, where they could easily be knocked or kicked by accident, which could cause the contents to become dislodged. In general the dispensary floors were cluttered. But shelving in the prescription storage area was found to contain many uncollected prescriptions from March, April and June, several months earlier. Removal of uncollected prescriptions may have provided useful space for storing more recent prescriptions, bulky and small. Dispensed prescriptions were stored so that patients' details could not be viewed by the public. The dispensary was generally clean and appropriately maintained although not as tidy as it could be. Overall, the pharmacy was bright and well ventilated with temperature control systems in place. It had a professional appearance and stocked a range of items for health and personal care.

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

Summary findings

The pharmacy makes its services available to everyone. Staff try to make sure pharmacy services are provided safely. And, in general, the pharmacy manages its medicines safely. But, it does not do enough to ensure that its procedures are followed. And, team members do not always give people the advice and information they need to help them use their medicines safely and properly. The pharmacy does not always properly label stocks of medicines which are not in their original packs. And it doesn't carry out all of its checks as thoroughly as it could.

Inspector's evidence

The pharmacy's external entrance had an automatic door and step -free access suitable for wheelchair users. The shop floor area was uncluttered and wide enough for wheelchair users to move around. The pharmacy had a prescription ordering service for a small number of patients who needed help to manage their prescriptions. Services were advertised at the front window for people to see and there was a variety of information leaflets available for customer selection. Information leaflets were placed in a rack near the waiting area.

In general, services were delivered in accordance with SOPs, but standardised procedures seem to have been established through general coaching and observation and the pharmacy did not have a documented SOP for each activity. Team members could not locate a SOP for the handing out of dispensed medicines or for the dispensing process, or for CD stock audits. Documented SOPs for these activities would help staff to deliver services in an informed, consistent and safe way. Pharmacists and experienced dispensers were observed offering verbal guidance to trainees, and the pre-reg said that she had been briefed on procedures and given an induction. But, SOPs would be beneficial for a team with several staff members who were inexperienced or in training, such as the placement student, the trainee dispenser, the MCA and the pre-reg.

Multi-compartment compliance packs were provided for patients who needed them. Patient information leaflets (PILs) were offered with new medicines but not on a regular basis thereafter. The medication in compliance packs was not generally given a description, including colour and shape, to help people to identify them. The labelling directions on compliance packs did not give the required BNF advisory information to help people take their medicines properly. Medicines summary sheets were created for each person and checked against prescriptions each time. Compliance packs were dispensed against the summary sheet and prescription. They were then sealed but not labelled until after they were dispensed. This meant that compliance packs containing medicines could be left unlabelled before completion.

The pharmacy had procedures for targeting and counselling all patients in the at-risk group taking sodium valproate. The pharmacy had the MHRA pack to hand including valproate warning cards, booklets and the guidance sheet for pharmacists. Packs of sodium valproate in stock bore the updated warning label and additional warning stickers were available for split packs.

Medicines and Medical equipment were obtained from: AAH, Alliance Healthcare, Phoenix, DE Pharmaceuticals, Colorama, NWOS, GD Cooper and Sigma. Unlicensed 'specials' were obtained from Thame labs and Sigma. All suppliers held the appropriate licences and stock was generally stored in an organised fashion. A CD cabinet and fridge were available for storing medicines for safe custody, or cold chain storage as required. Fridge temperatures were read, recorded and monitored to ensure that the medication inside was kept within the correct temperature range.

However, the pharmacy had several loose strips of medication on its shelves, including loose strips of carbocisteine 375 mg capsules, which had no expiry date, product licence number, batch number or any other manufacturer's information. This means they could be missed if subject to a product recall or safety alert. With a missing expiry date, they also could be handed out after they had gone out of date. Team members checked the quantity of CDs in stock at the time of dispensing but did not carry out a full audit of all CD stock on a regular basis. The pharmacy team were not scanning products with a unique barcode in accordance with the European Falsified Medicines Directive (FMD). The pharmacy had the FMD hardware and software but said they were not scanning products as they didn't have enough computers to manage the additional workload.

Stock was regularly date checked. But, there was an out-of-date split pack of bisoprolol 7.5mg found in amongst dispensing stock. In general, short-dated stock was identified and highlighted using a dot sticker. Waste medicines were disposed of in the appropriate containers for collection by a licensed waste contractor. The pharmacy didn't have a list of hazardous waste or a separate container for disposing it. The list would help staff to ensure that they were disposing of hazardous waste medicines properly. Drug recalls and safety alerts were responded to promptly and records were kept. The team had not found any stock affected by the recent recall for aripiprazole oral solution from 30/07/2019.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs to provide services safely. In general, the pharmacy uses its facilities and equipment to keep people's private information safe.

Inspector's evidence

The pharmacy had the measures, tablet and capsule counting equipment it needed. Measures were of the appropriate BS standard and clean. One triangle was found to have a slight dusty residue on it, but staff said they would clean it before use. Amber dispensing bottles were stored with their caps on to prevent contamination with dust and debris.

There were up to date information sources available in the form of a BNF, a BNF for children, the MEP and the drug tariff. The pharmacist said he also used the NPA advice line service. Pharmacists had access to a range of reputable online information sources such as the NHS websites, EMC a BNF 'app' NICE and the Drug Tariff. The pharmacy had two computer terminals in the dispensary. Both computers had a patient medication record (PMR) facility. They were password protected and were out of view of patients and the public. Patient sensitive documentation was stored out of public view in the pharmacy and confidential waste was collected. In general staff were not using their own smart cards when accessing PMRs. Staff should use their own smart cards to maintain an accurate audit trail and to ensure that access to patient records is appropriate and secure.

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.