General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Adams Pharmacy, 169 Mossley Road, ASHTON-UNDER-LYNE, Lancashire, OL6 6NE

Pharmacy reference: 1116832

Type of pharmacy: Community

Date of inspection: 08/11/2019

Pharmacy context

This is a busy community pharmacy located on a main road in the town centre. Most people who use the pharmacy are from the local area. The pharmacy mainly dispenses NHS prescriptions and sells a range of over-the-counter medicines. It supplies a large number of medicines in multi-compartment compliance aid packs to help people take their medicines at the right time. The pharmacy stays open for 100 hours per week and overnight on three nights.

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 adequately manages risks and takes some action to improve patient safety. It has written procedures on keeping people's private information safe and the team understands how it can help to protect the welfare of vulnerable people. It generally keeps the records required by law, but some details are missing, which could make it harder to understand what has happened if queries arise.

Inspector's evidence

The pharmacy had standard operating procedures (SOPs) for the services provided, with signatures showing that members of the pharmacy team had read and accepted them. The SOPs had been last reviewed in December 2017 and were due for another review. There was a roles and responsibilities SOPs. Some of the details had not been completed, but the pharmacy team members were performing duties which were in line with their role. The apprentice dispenser was wearing a uniform, but none of the other members of the team were, and there was nothing to indicate their role, so this might not be clear to members of the public. The notice showing the name of the responsible pharmacist (RP) was on the floor at the start of the inspection but it was put on display shortly after.

Dispensing incidents were reported and actions taken to prevent re-occurrence were recorded. For example, following an incident when the incorrect strength of metformin was supplied, it was identified that the team were rushing and not carried out a thorough accuracy check. The learning point was that a second check must always be carried out, even if a self-check was necessary. In these circumstances the second check must be carried out after a short break. Near misses were recorded and reviewed, although the review was not usually documented. Learnings were shared with the pharmacy team. For example, the similar packaging of Milpharm's gabapentin 300mg and carbocisteine 375mg was pointed out to the team, and the dispensary shelves were checked in case they had become mixed together. One of the owners contacted their wholesalers to point out the similarity and asked to receive a different brand of one of the medicines to avoid errors. 'Warning LASA' (look-alike and sound-alike drugs) notes were placed on the dispensary shelves in front of some medicines such as allopurinol and amitriptyline so extra care would be taken when selecting these.

There was a 'dealing with complaints' SOP, but there was nothing on display in the pharmacy with the complaints procedure and the details of who to complain to, so people might not know how to raise a concern or provide feedback. A customer satisfaction survey was carried out annually. The results were on display behind the medicine counter and available on www.NHS.uk website. Areas of strength (rated 100%) included the service provided by the pharmacist and pharmacy staff and providing an efficient service. An area identified which required improvement was providing healthy living advice, so the team had increased their focus on this.

One of the owners confirmed that the indemnity insurance had been renewed, as the certificate on display had expired at the end of October 2019. Private prescription and emergency supply records were recorded electronically. The RP record was appropriately maintained. The controlled drug (CD) register was generally in order, but some headers were missing from the tops of pages, and some of the writing was difficult to read. This might make it harder to understand what had happened if something went wrong. Records of CD running balances were usually kept and these were audited. Two CD

balances were checked and found to be correct.

Members of the pharmacy team had read and signed a confidentiality agreement. There was an electronic version of a data security protection document but no record that the team had read this. There were separate bins for confidential waste and general waste. The confidential waste was collected by an appropriate company. A member of the team correctly described the difference between confidential and general waste. Assembled prescriptions awaiting collection were not visible from the medicines counter.

The pharmacists had completed the Centre for Pharmacy Postgraduate Education (CPPE) level 2 training on safeguarding. The delivery driver said he would voice any concerns about vulnerable people to the pharmacist working at the time. There was nothing on display highlighting that people could be accompanied by a chaperone if requested, so people might not realise this was an option. Members of the pharmacy team had completed Dementia Friends training, so had a better understanding of patients living with this condition.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy team members are qualified for the jobs they do. The team members work well together and are comfortable providing feedback to their managers. They get some ongoing training to help them keep up to date. But this is not always structured or recorded, so gaps in their knowledge might not be identified and supported.

Inspector's evidence

There was a responsible pharmacist (RP), three NVQ2 qualified dispensers (or equivalent), an apprentice dispensing assistant and a delivery driver on duty at the time of the inspection. The staffing level was adequate for the volume of work during the inspection, and the team were observed working collaboratively with each other and the patients. Planned absences were usually organised so that not more than one person was away at a time. Absences were covered by re-arranging the staff rota or transferring staff from the neighbouring branch. The delivery driver from the neighbouring branch was helping out as one of the regular drivers was absent. The pharmacy had a pre-registration pharmacist, but she was not present at the inspection.

One of the owners was working as RP and the other owner was also present for most of the inspection. He arrived at the pharmacy when he was informed that an inspection was taking place. He explained that he was the regular pharmacist who mainly worked at the pharmacy, but the two owners jointly managed the pharmacy along with two regular locum-pharmacists. He said that onsite team discussion took place when possible, but the team also used the WhatsApp messenger system to communicate. There were several different groups which members of the team could be part of, depending on their role. There was a WhatsApp SOP group which was used to inform the team of changes to procedures. Around two messages were sent each month in this group and were in the form of text or video.

The apprentice dispenser was on a course organised through a local college. She confirmed that she had read the SOPs when she first started working at the pharmacy. There was an induction checklist, however the completion of it was not recorded. The pre-registration pharmacist and apprentice dispenser, who were both on structured courses, had protected training time and formal appraisals. The rest of the pharmacy team discussed performance and development informally. They did not have regular structured training but the owners sent training material through on one of the WhatsApp groups when they thought it was required. There had been recent training videos provided on prescriptions exemptions and how and when to use ‘not dispensed’ on prescriptions.

One of the team members said she felt there was an open and honest culture in the pharmacy and said she would feel comfortable talking to one of the owners about any concerns she might have. She felt the team could make suggestions or criticisms informally. One of the owners said he empowered the pharmacists in the team to exercise their professional judgement and comply with their professional and legal obligations. For example, refusing to sell a pharmacy medicine because they felt it was inappropriate. He said targets were set for some services such as Medicines Use Review (MUR) but these were for the whole team and there was no pressure on individuals to achieve them.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises generally provide a professional environment for people to receive healthcare. The pharmacy has a private consultation room that enables it to provide people with the opportunity to have confidential conversations. But it is cluttered and untidy which detracts from the professional image of the pharmacy.

Inspector's evidence

The pharmacy premises including the shop front and facia were reasonably clean and in an adequate state of repair. The retail area was free from obstructions, professional in appearance and had a waiting area with several chairs. The temperature and lighting were adequately controlled. Maintenance problems were reported to the owners, who decided whether to contact the landlord or organise for the work to be carried out themselves. The response time was appropriate to the nature of the issue. The pharmacy was relatively small for the volume of prescriptions and shelf and bench space were very limited. The pharmacy used the building next door to store excess stock and complete administrational duties. But all activities which were required to be carried out in a registered pharmacy took place in the pharmacy. The pharmacy traded overnight on three nights and people were served through a hatch in the side wall of the pharmacy after 8pm, as a security precaution.

Staff facilities included a WC with a wash hand basin and hand wash. The doorway into the WC contained baskets of prescriptions making it difficult to access. There was an additional WC and kitchen area in the building next door which the pharmacy team usually used. There was a separate dispensary sink for medicines preparation with hot and cold running water. Hand sanitizer gel was available.

The consultation room was cluttered with fixtures and fittings, shelves, brackets and empty plastic tote trays compromising its professional image. The availability of the room was highlighted by a sign on the door. The pharmacy team used the room when carrying out services and when customers needed a private area to talk.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy offers healthcare services which are easy for people to access. Services are generally well managed, so people receive appropriate care. The pharmacy gets its medicines from reputable sources. And it carries out some checks to ensure medicines are in good condition and suitable to supply.

Inspector's evidence

The pharmacy, consultation room and pharmacy counter were accessible to all, including patients with mobility difficulties and wheelchair users. Some of the services provided by the pharmacy were advertised in the window along with the opening hours. There was a small range of healthcare leaflets and some health promotion posters encouraging exercise. There were books on common conditions which were available for purchase or people could read these whilst waiting for their prescription. The pharmacy team were clear what services were offered and where to signpost to a service not offered. Signposting and providing healthy living advice were recorded in the form of a tally chart. A large number had been recorded in October 2019. However, it was difficult to monitor the effectiveness of the health promotional activities as outcomes for patients were not recorded. The tally chart also included signposting and healthy living advice provided in MURs and as part of NMS.

The pharmacy offered a repeat prescription ordering service and patients were usually contacted before their prescriptions were due, to check their requirements. One of the owners explained that on some occasions it was not possible to get in touch with patients before their medication ran out, and if they were considered vulnerable patients, they would let their GP know that they were ordering their medication without having contacted them.

There was a delivery service with associated audit trail. Each delivery was recorded, and a signature was obtained from the recipient. A note was left if nobody was available to receive the delivery and the medicine was returned to the pharmacy. The delivery driver described the delivery process which was in line with the SOP.

Space was very limited in the dispensary but the work flow was organised into separate areas with a designated checking area. The dispensary shelves were reasonably neat and tidy with cardboard separators to improve the organisation. Dispensed by and checked by boxes were initialled on the medication labels to provide an audit trail. Different coloured baskets were used to improve the organisation in the dispensary and prevent prescriptions becoming mixed up. The baskets were stacked to make more bench space available but some baskets containing stock to be used to assemble multi-compartment compliance aid packs were stored on the floor which was unhygienic.

Stickers were put on assembled prescription bags to indicate when a fridge line or CD was prescribed. ‘Post-it’ notes were used to highlight counselling was required and high-risk medicines such as warfarin were targeted for extra checks and counselling. INR levels were requested but not usually recorded when dispensing warfarin prescriptions. ‘Post-it’ notes were used to pass messages to the patient from their GP. For example, if a review was required before their next prescription would be issued. The team were aware of the valproate pregnancy prevention programme. An audit had been carried out and one or two patients in the at-risk group had been identified. The pharmacy had telephoned these patients and discussed pregnancy prevention with them, but it was not clear if this had been recorded

on their medication record .The valproate information pack and care cards were available to ensure people in the at-risk group were given the appropriate information and counselling.

A large number of multi-compartment compliance aid packs (around 100) were supplied by the pharmacy and they had reached their maximum capacity because of space limitations. Recently, new patients had only been accepted following direct referral from their GP and after completion of an assessment for appropriateness by their GP. A dispensing audit trail was completed, and medicine descriptions were usually included on the labels to enable identification of the individual medicines. Disposable equipment was used. There was a partial audit trail for changes to medication in the packs, but it was not always clear who had confirmed the changes and the date the changes had been made, which could cause confusion in the event of a query.

A member of the pharmacy team knew what questions to ask when making a medicine sale and when to refer the patient to a pharmacist. She was clear which medicines could be sold in the presence and absence of a pharmacist and understood what action to take if she suspected a customer might be abusing medicines such as a codeine containing product. Pharmacy medicines were stored behind the medicine counter so that sales could be controlled. CDs were generally stored appropriately. Date expired and patient returned CDs were segregated.

Recognised licensed wholesalers were used to obtain medicines and appropriate records were maintained for medicines ordered from 'Specials'. No extemporaneous dispensing was carried out. The pharmacy was not compliant with the Falsified Medicines Directive (FMD). They were not registered with SercurMed and did not have the software needed to comply so were not currently scanning to verify or decommission medicines. They were still taking advice about which system to use. Medicines were generally stored in their original containers at an appropriate temperature. Date checking was carried out and documented. Short dated stock was highlighted. Dates had been added to opened liquids with limited stability. Expired medicines were segregated and placed in designated bins.

Alerts and recalls were received via e-mail messages from the NHS and the MHRA. The details were shared with the pharmacy team via a WhatsApp group. The e-mails were acted on and retained on the computer, but the action taken was not recorded. So, the team might be able to easily respond to queries and provide assurance that the appropriate action had been taken. One of the owners suggested he would set up a record sheet on the computer to capture this information.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

Members of the pharmacy team have the equipment and facilities they need for the services they provide. They maintain the equipment so that it is safe and use it in a way that protects privacy.

Inspector's evidence

Recent copies of British National Formulary (BNF) and BNF for children were available and the pharmacist could access the internet for the most up-to-date information. There were two clean medical fridges. The minimum and maximum temperatures were being recorded regularly and had been within range throughout the last few months. All electrical equipment appeared to be in good working order.

The pharmacy had a large range of plastic measures which did not have recognised calibration or accuracy marks. This could possibly compromise accuracy when preparing liquid medicines. One of the owners said he had checked the accuracy of the plastic measures against glass measures with accuracy stamps, and confirmed they were accurate before use. He said they were always thoroughly washed after use. The pharmacy had a range of equipment for counting loose tablets and capsules. Medicine were appropriately capped to prevent contamination. Computer screens were positioned so that they weren't visible from the public areas of the pharmacy. Cordless phones were available in the pharmacy, so staff could move to a private area if the phone call warranted privacy.

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.