General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: HBS Pharmacy, Moor Park Avenue, Entrance Off St Thomas Road, PRESTON, PR1 6AS

Pharmacy reference: 1116946

Type of pharmacy: Community

Date of inspection: 13/11/2019

Pharmacy context

The pharmacy premises are not open to the public and all supplies of medicines are made by delivery. It is situated in the residential area of Deepdale, in Preston. The pharmacy dispenses NHS prescriptions and some private prescriptions. Its sole business is the provision of care home services, with medicines supplied in original packs or in multi-compartment compliance aids.

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 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 not all met	4.3	Standard not met	Medicines are left in unsealed blisters for a prolonged period of time. This may affect their stability and could increase the risk of error.
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. And members of the team are given training so that they know how to keep private information safe. They record things that go wrong and discuss them to help identify learning and reduce the chances of similar mistakes happening again. But the pharmacy has not completed a risk assessment or an audit for the services it provides. So it may not be able to demonstrate all the associated risks have been identified and are being appropriately managed.

Inspector's evidence

There was a current set of Standard Operating Procedures (SOPs) which were issued in July 2018 and their stated date of review was July 2020. But some members of the pharmacy team had not signed any of the SOPs. So they may not know what is expected of them or where responsibility lies. The pharmacy had not conducted a risk assessment of its activities. And there were no routine audits about the services provided to help identify possible improvements. So the pharmacy may not be doing all it can to identify and manage the risks associated with the services it provides.

Dispensing errors were recorded. A recent error involved the supply of the incorrect strength of trazodone. The pharmacist had investigated the error and discussed her findings with the pharmacy team. Near miss errors were recorded on a paper log and analysed by the pharmacy technician to identify trends or underlying factors. The pharmacist said she would discuss the review with staff each month. But there was no record of actions taken by the pharmacy team following the reviews. So they may not always be able to demonstrate learning they had identified. The pharmacist gave some examples of action that had been taken to help prevent similar mistakes. For example, placing a sticker near different strengths of amitriptyline to remind people to take care whilst picking the medicines. She said she also highlighted mistakes to staff at the point of accuracy check and asked them to rectify their own errors.

Roles and responsibilities of staff were described in individual SOPs. The trainee dispenser was able to describe what his 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. Details about this were provided to care homes as part of their written agreement, so they knew about how to provide feedback or make a complaint to the pharmacy. Complaints were directed to the pharmacy manager to be followed up. A current certificate of professional indemnity insurance was seen.

Controlled Drugs (CDs) registers were maintained with running balances recorded and generally checked monthly. A spot check of three balances was completed. One was found to be correct, another was found to have a deficit of 1 tablet, and another was found to have a balance recording error. A register for patient returned CDs was available. The records for the RP, private prescriptions, emergency supplies and unlicensed specials appeared to be in order.

An information governance (IG) policy was available. The pharmacy team had GDPR training and each member had signed a confidentiality agreement. When questioned, the trainee dispenser was able to describe how confidential waste was segregated to be destroyed using the on-site shredder. Details of

the company's privacy notice was provided to each care home, to provide information about how people's data was handled.

Safeguarding procedures were included in a separate folder and used by the pharmacy team for their training. The pharmacists said they had completed level 2 safeguarding training. Contact details of the local safeguarding board were kept in a folder. The trainee dispenser said he 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 appropriately trained for the jobs they do. Members of the pharmacy team complete some additional training to help them keep their knowledge up to date. And they get regular feedback from their manager to help them improve.

Inspector's evidence

The pharmacy employed two pharmacists, a pharmacy technician who worked as an accuracy checker (ACT), nine dispensers – four of whom were in training, and three new members of staff still on probation. Members of the team had completed the necessary training for their roles. The normal staffing level was a pharmacist, ACT and 7 other staff. The volume of work appeared to be managed effectively. Staffing levels were maintained by part-time staff and a staggered holiday system. Relief staff could be requested from local branches. The ACT was absent, and a second pharmacist was present to provide cover.

Staff were provided regular training from the pharmacist during weekly briefings. The topics appeared relevant to the people attending the training. But this was not always recorded. So learning needs may not always be appropriately managed.

The pharmacist said she was able to exercise her professional judgement, and this was respected by the pharmacy team and the company. The trainee dispenser said she received a good level of support from the pharmacist and felt able to ask for further help if she needed it. A trainee dispenser was able to describe what she would do if there was an unexpected dose prescribed for a patient. This involved contacting the GP surgery to clarify the dosage and referring the outcome to the pharmacist.

Appraisals were conducted by the pharmacist every three to six months. A trainee dispenser said he felt that the appraisal process was a good chance to receive feedback and he felt able to speak about any of his own concerns. He said if he had any concerns about the pharmacist he would be comfortable to speak to the manager or head office. There were no service based targets set by the pharmacy.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are suitable for the services provided. And the pharmacy provides information to people to enable them to use their services.

Inspector's evidence

Members of the public could not access the pharmacy and all services were provided at a distance. Information about the pharmacy was provided to care homes before services began. There was a website to provide some information. For example, the pharmacy's opening hours, address and contact details. But the website had also not been updated since the change in brand of multicompartment compliance aids. So the information may be inaccurate and misleading.

The pharmacy was clean and tidy and appeared adequately maintained. The size of the dispensary was sufficient for the workload. There were multiple workbenches laid out in a classroom like style and each was designated for a particular care home. A sink and washing facilities were available within the dispensary. The temperature was controlled in the pharmacy by the use of an air conditioning system. Lighting was sufficient. The staff had access to a canteen and WC facilities.

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

Summary findings

The pharmacy's services are managed effectively. Some medicines are supplied in multi compartment compliance aids. But the trays are left unsealed for up to two days while they are being prepared. So there may be more chance of things going wrong. Members of the pharmacy team do not always complete additional checks when they supply higher-risk medicines. So they might not always make sure they are still suitable.

Inspector's evidence

The pharmacy provided services to care homes who had signed up as part of a service level agreement. Information about the services on offer and details about the pharmacy were provided as part of agreements. Other people could not access the services it provided.

Information about people's regular medicines was kept on a record sheet for each person, and this had been clinically checked by the pharmacist. If there was a new medicine or a change in the dose, the prescription token was annotated and referred to the pharmacist for a new clinical check to take place. But the record sheet was not always updated, and there was no process to audit whether clinical checks were up to date. If there was no change since the previous prescription, the accuracy check was completed by the ACT. So there is a risk some important information may be overlooked, or some medicines may be supplied without adequate checks.

Medicines were dispensed to care homes either in conventional packs or in disposable 28-day multicompartment compliance aids (MDS). This was discussed and agreed with the care home when they first signed up to the pharmacy's services. The care home was responsible for identifying which medicines they needed each month. This was documented on a reordering sheet for the pharmacy to order repeat prescriptions from the GP surgery. The sheet also included any handover information such as dosage changes, discontinued medicines or items which were not required for that month. The pharmacy team matched the repeat prescriptions against the reordering sheet when they were received. Outstanding prescriptions were chased up by the pharmacy or the care home depending on their requirements.

A sealable plastic dispensing box was used for each patient. This contained the paperwork related to the patient and the relevant stock medicines were added to the box ready for the medicines to be dispensed. The dispensing boxes were kept sealed to prevent medicines being mixed up. Disposable 28-day compliance aids were in use, and these were sealed with a clear film and it contained the information needed under labelling requirements. The pharmacist said that MDS trays were assembled and checked within a period of 48 hours, during which time they were left unsealed. The side of each tray was initialled to provide an audit trail for who dispensed the medicines and who accuracy checked them. The accuracy check was completed before the tray had been sealed. It would then be sealed by another member of the team before being placed on delivery shelves. Medicines that were not suitable for inclusion in MDS trays were dispensed separately and bagged for individual patients.

Dispensed medicines were delivered in totes directly to the care home and a communication sheet was included. This contained details of any medicines that had changed compared to the reorder sheets. A delivery sheet was used and recorded information such as the number of boxes delivered, fridge items and CD items. There was a separate audit trail for CDs delivered with separate signatures obtained for

individual medicines. The care home was responsible for booking in the medication and ensuring the medication was present and correct. The care home would contact the pharmacy if there were any discrepancies. Patient information leaflets (PILs) were routinely provided.

The pharmacist said the legal check of a prescription was performed during the accuracy check. The expiry date of CD prescriptions was considered to ensure they would be supplied within the legal requirements. There were no additional checks when high-risk medicines (such as warfarin, lithium, and methotrexate) were dispensed. So staff may not always have sufficient information to establish if they remained suitable to supply. 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 she had a log of the care homes who had residents who met the risk criteria, and confirmed she had checked that appropriate safeguards were in place.

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 medicine directive (FMD), which is now a legal requirement. Equipment was installed but the pharmacy team had yet to commence routine safety checks of medicines. Stock was date checked on a monthly basis. A date checking matrix was signed by staff and shelving was cleaned as part of the process. Short dated stock was highlighted using a sticker and recorded in a diary for it to be removed at the start of the month of expiry. Liquid medication 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 it had been in the correct range for the last 3 months. Patient returned medication was segregated from current stock in DOOP bins located away from the dispensary. Drug alerts were received by email from the MHRA. 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. And they maintain the equipment so that it is safe to use.

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, electrical equipment had been PAT tested. There was a selection of conical measures stamped with 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. Equipment was kept clean by the pharmacy team. There were no external windows of a height which would allow for patient information to be compromised.

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.