General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Springfield Pharmacy, 384 Liverpool Road, Eccles, MANCHESTER, M30 8QD

Pharmacy reference: 1118767

Type of pharmacy: Community

Date of inspection: 15/04/2019

Pharmacy context

A very busy pharmacy within a modern health centre in a residential area of Eccles. Most people who visit the pharmacy live locally. It primarily prepares NHS prescription medicines, and supplies a large number of weekly multi-compartment compliance aids, which are an aid to help people take their medicines safely. It also provides prescription ordering, home delivery and minor ailment consultation services. The pharmacy provides a range of other NHS services, including Medicines Use Reviews (MURs), Emergency Hormonal Contraception (EHC), substance misuse treatment, and flu vaccinations.

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 not all met	2.1	Standard not met	There are not enough staff to manage the volume and nature of the workload. This means that some people experience delays in receiving their medicines.
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 has written instructions for the pharmacy team to follow to help make sure that people receive safe services. But, not everyone in the team has read them, which may increase the risk of mistakes happening. The pharmacy team members aim to record and learn from their mistakes. But they do not do this as effectively as they could. So, they may miss learning opportunities. Everyone in the pharmacy team receives training, so they know how to keep people's private information secure. Some of the team understand they have a role in protecting vulnerable people. But, not all of them have received formal training, which may mean they are not sure how to identify vulnerable people or deal with safeguarding concerns.

Inspector's evidence

The pharmacy had written procedures, which were issued in December 2018 and due for review in December 2020. These covered the general principles of dispensing medicines safely and the responsible pharmacist (RP) regulations. However, except for methotrexate dispensing, there were no written procedures for dispensing medicines considered to be high risk, including anti-coagulants, lithium, insulin, valproate and fentanyl patches. Also, apart from the superintendent, who was one of the regular pharmacists, none of the remaining staff, including two trainee dispensers, had signed to declare they had read and understood the procedures. So the team might not always work effectively.

Dispensary staff started dispensing anytime from 6.30am to 7am, and the RP arrived anytime from 6.45am to 8.30am. So, there were periods when dispensing services operated without an RP, contrary to the RP regulations. The superintendent said that they would make sure dispensing did not start until the RP was present.

The pharmacy team recorded mistakes they identified while dispensing medicines. And they addressed each mistake in isolation. But the team often did not record why they had made each error. So it was harder for them to identify trends or hidden risks in the dispensing process.

The pharmacy team received positive feedback in the last patient satisfaction survey conducted between April 2018 and March 2019. There was no publicly displayed information about how patients could raise concerns. The superintendent said that staff knew about the existence of the pharmacy's complaint procedure, but not all of them had read it. So, the pharmacy could miss opportunities to receive feedback on the services it provided.

The pharmacy had professional indemnity cover for the services they provided. Records were kept in order for identifying the responsible pharmacist, minor ailment consultations, and controlled drug (CD) transactions.

Everyone in the pharmacy team had signed to declare they had read detailed policies on protecting patient data and confidentiality agreements. They had also completed GDPR training. However, an internal audit on protecting patient data was still to be completed, so potential risks might not always be identified. This was reflected in the pharmacy team constantly using the RP's (and locum pharmacist's) security card to access patient data, instead of their own. Although the team secured

confidential waste, arrangements to securely destroy it were still to be established. The superintendent said that she would prioritise addressing these matters.

The superintendent said that all the employed pharmacists were level 2 safeguarding accredited. And the pharmacy had written safeguarding procedures. However, apart from the superintendent, none of the staff had signed to declare they had read and understood them.

Staff said that the delivery driver knew their compliance aid patients well, and had raised concerns about their welfare in the past. However, staff involved in dispensing compliance packs had little or no contact with these patients, and records detailing each patient's care background, circumstances, and arrangements were not kept. A system for recording safeguarding concerns and who they were shared with was not in place.

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

Summary findings

There are not enough staff to manage the workload given the volume and type of services provided. And there are not enough experienced team members able to prepare multi-compartment compliance aids. This means the pharmacy may not always be able to supply people's medicines on time. Pharmacy team members complete the necessary training for their role. But they do not have formal training plans or receive feedback through an appraisal process. This could mean that gaps in their skills and knowledge are not identified and supported.

Inspector's evidence

The staff present were: the superintendent and co-owner who worked five days a week; an RP and locum pharmacist who recently started covering three days per week; two dispensers who had worked at the pharmacy for several years; one recently recruited experienced dispenser; and two trainee dispensers.

The other staff employed were: a locum pharmacist covering two days per week; an experienced dispenser and a delivery driver.

Since the owners acquired the pharmacy in December 2018, several dispensers and the regular pharmacist had left. A dispenser had been recruited to address the staff shortages. And two trainee dispensers, who were new to pharmacy, had also been recruited around a month ago, so still had to gain the necessary skills to dispense competently and independently. But they were still short staffed. The superintendent said that they had focussed intensely on recruiting another dispenser, with one leaving shortly after starting, but they were struggling to fill the vacancy. During this difficult transition, the superintendent pharmacist had also worked full-time since February 2019, primarily in a dispenser role. However, the team still experienced constant workload pressures that could only be partly attributed to the impending Easter break.

Workload pressures were intensified by the scale of dispensing (approximately 16,000 items per month), and the high volume of walk-in prescriptions from the health centre. In addition, the imminent closure of another nearby pharmacy had led to a significant increase in the number of repeat prescription and compliance aid patients. The superintendent estimated this could increase further by a few thousand items, significantly increasing the workload. This was reflected in the constant queues of five to ten patients either waiting up to 30 minutes for their prescription medicine, and the countless number of stacked baskets of part-dispensed medicines, including compliance aids, that were either awaiting stock or a pharmacist check, occupying most of the dispensing bench space, as there was no other accredited staff, to accuracy them. Medicine stock expiry date-checking had also, consequently, been affected, with many sections having not been checked for several months. To avoid patients being without medication, staff worked extra hours during the weekend, early mornings and later in the evening when the pharmacy was closed. However, there was still a backlog of work, and many repeat prescriptions were often still not ready on time. This was reflected in several patients saying they had run out of medication. Consequently, staff morale was low and they were at risk of becoming fatigued. The superintendent said that the health-centre was unwilling to issue repeat prescriptions earlier to help them manage the workload better, but she would try to arrange a further meeting with

them. However, there was no realistic prospect in the short or medium-term of this being resolved.

Only one of the dispensers had the necessary skills, knowledge and experience to competently and independently dispense multi-compartment compliance aids. Consequently, compliance aids were typically not dispensed until the day they were due to be delivered. And, frequently the driver had to delay their delivery round while the dispenser finished dispensing several compliance aids.

Similarly, only the pharmacist participated in preparing CD instalments, meaning only they checked instalments that they assembled. And, they did not prepare instalments until patients presented. So, pharmacists could experience moments of increased workload pressure at these times.

The superintendent said, as the pharmacy had recently been acquired, the focus was on training staff on the new procedures. New staff participated in an induction process. However, there were no plans to introduce a structured appraisal process and training programme or equivalent for existing accredited staff.

Near-miss events were brought to the team's attention at the time of each event. However, they did not necessarily reflect on why or the circumstances under which they occurred, as reflected by their omission from corresponding records. So, they might have missed learning from mistakes. This was particularly significant with the two new trainee staff.

Although pharmacists reviewed each month's near-miss records, the team were not involved, further reducing the opportunity for the team to be engaged in managing patient safety.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises are suitable for the services provided. And it has a place where people can talk privately.

Inspector's evidence

The level of cleanliness was appropriate for the services provided. There was sufficient space in the dispensary to allow medicines to be dispensed safely for the scale of services provided.

The consultation room offered the privacy necessary to enable confidential discussion, but had limited signposting e.g. it was not advertised in the front window.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy generally prepares prescription medicines safely. But, the staff shortages and inefficient systems may mean some people experience delays in receiving their medicines. The team provides some additional support to people who take medicines considered to be higher risk. But they do not supply people receiving weekly multi-compartment compliance aids with all the information they might need to take their medicines safely. The pharmacy gets its medicines from licensed suppliers and keeps medicines needing refrigeration at the correct temperature. But it does not check the expiry dates on some of its medicine stock as often as it should. So, it could give out medicines that may not be fit for people to use.

Inspector's evidence

The pharmacy was open from 8.30am to 6.30pm Monday to Friday. The pharmacy had a step-free entrance with automatic doors, and the pharmacy team could see anyone who required assistance accessing the premises.

The pharmacy team asked patients to confirm the repeat medications they required five working days before their prescription was due. This assisted in limiting medication wastage. However, the health centre would only issue prescriptions two days in advance, meaning there was minimal time to dispense prescriptions before patients needed them. Despite staff working before and after the pharmacy closed and at weekends, repeat medicines were typically not ready until a day after the patient was anticipated to need them.

The backlog of work and the countless part-dispensed medicines frequently led to prolonged periods when staff were trying to locate patient’s prescriptions when they presented to collect them. This also meant other work was further delayed. Matters were exacerbated as staff frequently commenced dispensing medication when they did not have sufficient stock to complete the labelling and assembly stages at the first attempt. Consequently, patients frequently complained about delays in supplies and the lack of communication.

Most compliance aid patients were limited to holding one week’s medication. The few remaining patients, who were supplied with a month’s medication, had carers who secured and administered their medication. So, the risk of patients taking too much medication or becoming confused about them were mitigated.

The pharmacy team scheduled when to order compliance aid patients’ prescriptions, which helped them to supply patients' medication in a timely manner. They kept a record of each patient's current medication that also stated the time of day they were to be taken, and queried differences between the record and prescriptions with the GP surgery before they dispensed medication. So, the team reduced the risk of patients who were more prone to medication changes being overlooked.

The pharmacy wrote communications about medication queries and changes for compliance aid patients alongside their list of current medication. So, it had a record that helped make sure these patients received only their currently prescribed medication. However, the record was not in a structured format, so there was potential to miss important information.

The pharmacy team used disposable compliance aids to dispense medicines for patients who needed extra support taking their medicines safely. However, they did not label compliance aids with descriptions of each medicine, making it more difficult for patients and carers to identify each of them, increasing the risk of patients becoming confused or anxious about their medicines.

The pharmacy team had screened patients who may become pregnant prescribed valproate to identify those who were potentially exposed to the teratogenic risks of it, with no patients identified. However, patients in the at-risk group taking valproate had not been issued the MHRA approved valproate card, contrary to national guidance, and the corresponding booklet was not available for any patients identified as being at risk.

The superintendent said that they routinely asked patients prescribed anti-coagulants to make sure they had their INR regularly monitored, and counselled them on their prescribed dose. They also reminded them of potential side effects or interactions during their annual MUR. However, they did not obtain their INR record.

The superintendent said that they routinely counselled methotrexate patients on their prescribed dose and to take folic acid, and reminded them about potential side effects or interactions during their annual MUR. However, they did not screen these patients for regular blood tests.

The superintendent said only they counselled patients on the safe use and disposal of fentanyl patches. She said she would provide guidance to the rest of the team, in particular the locum pharmacists.

The superintendent and RP (locum) pharmacist said they did not have any patients who were prescribed lithium. The pharmacy team used baskets to avoid each patient's medicines becoming confused with others during the dispensing process.

The pharmacy dispensed CD instalments for more than one day in divided daily doses, which supported patients taking a precise and accurate dose. However, it delayed dispensing instalments until patients presented, which had potential to increase workload pressure.

The dispenser and checker initialled dispensing labels to provide an audit trail, which assisted in investigating and managing risk in relation to near miss or dispensing incidents as well as providing some transparency around who was responsible for dispensing each medication.

The pharmacy team did not follow-up the significant number of patients who used the MUR service to establish whether their health had improved because of the service. So, the team did not have substantial data to show how effective the service overall was at improving patient health.

The pharmacy team obtained medicines from licensed pharmaceutical wholesalers and stored them appropriately. The superintendent said that the pharmacy was registered with the organisation responsible for establishing the UK medicines verification system to enable the Falsified Medicines Directive (FMD). They added that they were waiting for their supplier to provide the necessary software and hardware required to be FMD compliant. So, the pharmacy's system for adhering to the FMD was not yet live, as required by law.

The pharmacy team only left a protruding flap on medication stock cartons to signify they were part-used, which risked patients receiving the incorrect medication quantity.

The pharmacy team stored thermo-labile medicines in a refrigerator, and consistently monitored and recorded the refrigeration storage temperatures. So, they made sure these medicines stayed fit and safe for patient use. However, the refrigerator was full, which increased the risk of a selection error

while dispensing.

Records indicated that large sections of stock had not been checked for over several months, with the last section date-checked towards the end of January 2019. Written procedures for date-checking were also unclear about how often each section of stock should be checked. And, apart from the superintendent, none of the staff had signed to declare they had read and understood the procedures. This increases the risk that medicines could be supplied after they have expired.

The pharmacy team used an alpha-numerical system to store and retrieve bags of dispensed medication and the related prescription. So, the team could efficiently retrieve patients' medicines and prescription when they came to collect their medication. However, the large number of part-dispensed medications that patients came to collect and expected to be ready, negated the system's effectiveness, as the team spent considerable time searching both the storage area and vast number of baskets of part-dispensed medications.

The team said the delivery driver obtained recipient's signatures for medicines they delivered via an electronic system. However, they struggled to search electronic records for patients and recipients accepting receipt of delivered medicines, and were unable to find them. So, it was unclear how consistently the pharmacy safely and securely delivered medicines.

The team took appropriate action when they received alerts and recalls for medicines suspected of not being fit for purpose. They also made records related to the action taken. So, the team made sure patients did not receive potentially defective medicines.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs to provide the services it offers, and are designed to protect people's information.

Inspector's evidence

The pharmacy team kept the dispensary sink clean. They also had hot and cold running water and an anti-bacterial hand-sanitiser. So, they had facilities to make sure they did not contaminate medicines they handled.

The team had a range of clean measures, including separate ones for CDs. So, they could accurately give patients their prescribed volume of medicine.

The team had access to the latest versions of the BNF and cBNF online. So, they could refer to the latest clinical information for patients. The pharmacy team had facilities to store bags of dispensed medicines and their related prescriptions away from public view.

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.