General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Hood Manor Pharmacy, Great Sankey Medical Centre, Hood Manor Centre, Great Sankey, Warrington, Cheshire, WA5 1UH

Pharmacy reference: 9010061

Type of pharmacy: Community

Date of inspection: 09/12/2019

Pharmacy context

The pharmacy is next to a health centre, close to a parade of shops on the outskirts of Warrington. It mainly dispenses NHS prescriptions and sells a range of over-the-counter medicines. The pharmacy provides a range of services including seasonal flu vaccinations. The pharmacy supplies medicines in multi-compartment compliance packs to some people to help them take their medicines. And it delivers medicines to people's homes. It provides a substance misuse service, with observed supervised consumption.

Overall inspection outcome

✔ **Standards met**

Required Action: None

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Summary of notable practice for each principle

Principle	Principle finding	Exception standard reference	Notable practice	Why
1. Governance	Standards met	1.2	Good practice	The pharmacy team members consistently record their mistakes. And openly discuss them, so they can learn from them. They regularly review their records and take appropriate action to reduce the risks of mistakes in the future.
		1.8	Good practice	The pharmacy has a clear culture of safeguarding the safety and wellbeing of children and vulnerable adults. The pharmacy team members have a good knowledge of their role in supporting vulnerable people. They take responsibility to help these people and they take appropriate action to support their care.
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 identifies and appropriately manages the risks with its services. It has relevant and up-to-date written procedures for pharmacy team members to follow to help them work effectively. The pharmacy team members have a good knowledge of their role in supporting vulnerable people. And they take responsibility to help these people and take appropriate action to support their care. Pharmacy team members keep people's private information secure. And they mostly maintain the records they must keep by law. The pharmacy team members openly discuss and record their mistakes, so they can learn from them. And they take action to reduce the risks of mistakes in the future.

Inspector's evidence

The pharmacy held a set of up-to-date standard operating procedures (SOPs) relevant to the services provided. The SOPs had version control and an index to locate the required SOP easily. Of the sample checked, the SOPs had been reviewed in June 2019 and were due for the next review June 2021. The range of SOPs included ones for dispensing, dispensing with an accuracy checking technician (ACT) and responsible pharmacist (RP) regulations. There was a SOP detailing Falsified Medicines Directive (FMD) requirements. The pharmacy had SOPs for controlled drug (CD) management and for the services it provided, including seasonal flu vaccinations. The team members had completed a SOP training record, signed in 2019, after the last review.

The pharmacy had a SOP for near miss reporting. The pharmacy had separate near miss error logs held by the pharmacist and ACT. And the pharmacy team consistently made records of errors. The pharmacist or ACT held a discussion with the team member involved to raise initial awareness of the error. And further discussions were held as a team during meetings. The records indicated who had made the mistake and the time and date were logged. The team documented any action taken. This could have been more detailed on occasions. The pharmacist collected the near miss logs together each month and analysed the details of the errors to discuss at the meeting. The team had separated the salamol inhalers from salamol easibreathe and placed an alert on the shelves. There had been a further recent near miss in December. The pharmacist described how she would raise this at the next meeting. Earlier in the year, the team had identified the most common error as quantity errors. This had been repeated over several months. This had been documented as being discussed at meetings to raise awareness. And more recently the number of recorded errors for quantity had reduced. The pharmacy displayed a monthly safety record on the notice board in the dispensary for the team to view. The safety record was from November 2019. And detailed the number of near miss errors and dispensing incidents that had reached the patient. The pharmacy documented any errors that included look-alike and sound-alike (LASA) medicines. It displayed a summary of information about LASA medicines with a list of some of these medicines on the wall. The team had identified two errors with LASA medicines in November, these were highlighted for special discussion. And included amlodipine and amitriptyline. The pharmacy held a monthly safety briefing with the team. The pharmacy reported dispensing incidents and the team members discussed learning from a recent error during the inspection. They described how a prescription had been labelled with the incorrect person's name. In addition to raising awareness about the error, they had identified this was potentially a General Data Protection Regulation (GDPR) breach and had reported it to the GDPR lead.

The pharmacist displayed the correct RP notice. The pharmacy team members understood their roles

and responsibilities. They described what tasks they could and couldn't complete in the absence of the RP. And were seen completing tasks associated with their roles throughout the inspection. This included the pharmacist completing clinical checks and the ACT completing accuracy checks of prescriptions. The pharmacist and ACT completed their checks on separate benches at right angles to each other so the pharmacist could easily supervise and support the ACT's activities. And they were following clear processes to ensure safe and effective working. For any prescriptions where the accuracy check was completed prior to the clinical check, the ACT ensured the prescriptions and medicines were clearly segregated away from those ready for hand out next to her checking bench. This meant they were not handed out without the required clinical check.

The pharmacy had a SOP relating to handling complaints. It advertised the complaints procedure to people in its practice leaflet. A team member described what she would do in the event a complaint required escalation. She described how she would speak to her manager. And if necessary, would escalate to the company's head office. She was confident to do this and pointed out the head office details she would use. The pharmacy asked people for feedback using an annual questionnaire (CPPQ). And the pharmacy team displayed the last survey results from 2018-2019 on a notice board in the pharmacy retail area. A team member described how changes had been made to stock management in the dispensary following feedback from people using the pharmacy.

The pharmacy had up-to-date professional indemnity insurance. Records for private prescriptions and emergency supplies complied with requirements. The pharmacy kept the RP record electronically and entries were complete and up to date. The records kept for the supply of unlicensed medicines were mostly complete. But a few records checked didn't have the prescriber's details completed on the certificates of conformity. The pharmacy kept the required CD records electronically. And these were up to date. When checked during the inspection, the quantity of oxycodone (Longtec) 5 mg PR tablets in the CD cabinet did not match the CD register entry. This discrepancy was resolved when a missed entry was identified. The electronic CD register was amended accordingly. A check on fentanyl 25 microgram patches confirmed the register entry matched the physical stock quantity. For the entries examined in the CD register, the pharmacy mostly checked the CD balances against the physical stock monthly, and sometimes more often. The system alerted the user when CD balance checks were due. There was an alert on the system indicating some checks were nine days overdue.

The pharmacy team members were aware of the importance of keeping people's information safe. The pharmacy had SOPs relevant to GDPR. And the team had read the SOPs. The delivery drivers described the importance of not sharing people's details when they obtained signatures for their deliveries. The team members separated confidential waste and had it destroyed off site. The pharmacy displayed a privacy statement in the retail area, which detailed the named data protection officer. The pharmacy displayed a 'sharing of information' poster displayed behind the pharmacy counter to inform people how their data was handled.

The pharmacy had a SOP relating to vulnerable children and adults, which team members had read. The pharmacist and ACT had completed safeguarding level two training. The ACT described how the team had supported a person with their individual needs. The pharmacy displayed the details of local safeguarding contacts and a process flow chart on the dispensary wall. The team had a good knowledge of their roles in safeguarding vulnerable people. The drivers described how they would refer any concerns they had with vulnerable people back to the pharmacist. And would report if someone they delivered to regularly was becoming more confused. So, the pharmacist could talk to the surgery or their relatives. The pharmacy had a chaperone policy and a sign indicating to people they could have a chaperone for services.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has suitably skilled and qualified people providing its services. It is good at supporting its team members in training. And it provides some ongoing training opportunities for other team members. Team members feel comfortable to share their ideas to improve ways of working. And to raise professional concerns if they need to.

Inspector's evidence

During the inspection the pharmacist manager was the RP. She worked three days and another regular pharmacist worked the other two days. She was supported by an ACT, who worked 24 hours, a full-time pre-registration pharmacist, a full-time apprentice (who had started in August), a full-time level two dispenser and a part-time level two dispenser. The pharmacy employed two other qualified dispensary team members and two part-time delivery drivers. The pharmacist manager completed staffing rotas and described how she encouraged the team to complete their holiday forms early. So, any staffing cover could be organised well in advance. They usually covered each other's holidays and absence. There was the option for team members from other local branches to cover or the use of agency staff. The pharmacy had front and back dispensing areas. There was a team member allocated to work in the front area and they were responsible to attend to people waiting at the pharmacy counter. During the inspection the team member wasn't always present in the front dispensing area, which meant that sometimes people waited some time at the counter to be acknowledged and attended to. The inspector waited a little while to be acknowledged as the team member allocated to the front area had a query that had meant him leaving the front area. And there was a second person waiting before the inspector. Another team member didn't cover the counter during this time. The team member covering this area at times appeared under pressure to complete the tasks associated with the people who were waiting.

The pharmacist utilised the ACT's skills to help with the effective completion of dispensing and services. And they worked well together throughout the inspection. The ACT led on the organisation of the compliance pack dispensing workload. She was seen effectively managing and supporting the team members dispensing compliance packs. And they worked on adjoining benches so she could support them easily. All pharmacy team members were observed completing tasks competently. And managing the workload in an organised manner. They worked well together, discussing their tasks and any mistakes they made in an open and honest way. They provided appropriate advice and answered queries competently within their expertise. They were seen referring queries appropriately to the pharmacist. The pharmacy displayed an up-to-date rota, detailing individual responsibilities for tasks on the notice board in the dispensary.

The team members completed some learning in addition to their qualification training. For example, the pharmacist had updated the team with regards to the changes in CD schedules of pregabalin and gabapentin. The regular pharmacists had completed training relevant to their roles and services provided. The training certificates and declaration of competence were seen for the flu vaccination services. And they had completed level two safeguarding training. The pre-registration pharmacist received five hours per week of protected study time. The two regular pharmacists were her tutors, this had been arranged for good continuity throughout the year. And she found them both very supportive. They regularly asked her questions on an informal basis and completed coaching on the job. She felt she

was making good progress and that she had improved in confidence speaking with people and providing advice. She received feedback on her performance from her tutor after they observed her interactions with people. She knew how to raise a concern firstly with her manager and felt comfortable to escalate any professional concern to head office. The pharmacy had a whistleblowing SOP, detailing how to raise an anonymous concern.

Pharmacy team members described how they held regular meetings, mainly to discuss patient safety and near misses. They also discussed the most effective action to take following errors, any ideas to improve services and changes to ways of working. A team member described one idea they had discussed with regards to the storage of fast moving stock lines and their stock control. This was to reduce the number of owings on regularly used medicines. A team member described a one-to-one meeting with her manager, where she had discussed how she was doing in her role, how she could improve and what she was doing well. Following the discussion, she had been given responsibilities for date checking. The pharmacy set the team some targets to achieve. The team monitored the progress with these performance indicators. The pharmacist described how she used her professional judgement to provide services relevant to people's health needs.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy provides its healthcare services in a professional environment. The premises are clean and secure. And it has a suitably sized consultation room for people to speak with team members in private.

Inspector's evidence

The pharmacy premises adjoined the health centre, with access from the health centre and also the street. The pharmacy could restrict access from the health centre when closed with a shutter. The pharmacy had appropriate security measures. The lighting and temperature in the pharmacy was sufficient. The pharmacy had two areas designated for dispensing, with enough bench space for the services provided. This included a separate area for dispensing multi-compartment compliance packs. And separate checking areas for the pharmacist and the ACT. It had adequate storage space. Some items were stored on the floor, including prescriptions awaiting collection. This was not ideal, but items were stored tidily to prevent a trip hazard. The pharmacy was generally clean and portrayed a professional appearance. There was some dirt on the floor, but this was swept up during the inspection.

The consultation room was clean and of a suitable size. It had a sink with handwashing facilities and hot and cold running water. No confidential information was kept on show in the room. The team kept the door locked when not in use. But it didn’t have signage on or above the door to promote the availability of the room as a consultation room.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's services are easily accessible. And the pharmacy provides a range of services to meet people's health needs. It manages its services effectively and delivers them safely. The pharmacy keeps audit trails for the services it provides. So, it can respond easily to people's queries. And so, the team can make sure people receive their medicines when they need them. The pharmacy obtains its medicines from licenced sources. And it stores and manages its medicines appropriately.

Inspector's evidence

The pharmacy's premises had level access from the pavement outside through a set of double automatic doors. And there was a ramp to provide access into the health centre. The pharmacy advertised its opening hours on the outside of the premises, so these could be viewed by people when the pharmacy was closed. The pharmacy displayed posters in the pharmacy retail area promoting services such as the new medicines service (NMS) and flu vaccinations. It had 'Choose Well' health messages on a television screen. The pharmacy had a practice leaflet advertising its opening hours and services.

The pharmacy offered a flu and travel vaccination service. It had up-to-date patient group directions (PGDs) for the services. Examples of PGDs seen were for NHS and private flu vaccinations. And for Japanese encephalitis, rabies and typhoid vaccinations. The pharmacist described how the flu vaccination service was popular, but few travel vaccinations were administered due to the service offered at the surgery. The pharmacy had signed up to provide the Community Pharmacist Consultation Service (CPCS) but had not as yet received many referrals. The pharmacist described how she organised the services workload when the pharmacy team was not as busy dispensing. This allowed her to take the time to speak to people, for example making telephone calls as part of the NMS service. And provide a blood pressure monitoring service associated with The Heart Foundation and the local NHS clinical commissioning group (CCG)

The pharmacy team members used baskets throughout the dispensing process, to help reduce the risk of error. They used different coloured ones, for example for children's prescriptions to raise awareness to the team. They kept a dispensing audit trail as the team members signed the dispensed by and checked by boxes on the dispensing labels. The pharmacy had an organised workflow, with separate areas for labelling, dispensing and checking prescriptions. They used stickers to highlight fridge and CD lines. The pharmacy dispensed methadone to people. And some received their doses as part of a supervised consumption service. The pharmacy prepared the doses in advance and stored them appropriately in the CD cabinet. It kept the supervised and non-supervised doses clearly separated. The pharmacist and pharmacy team members were aware of the requirements of the valproate safety alert. And the requirement for people at risk to be on a pregnancy prevention programme. The team had identified one person fitting the criteria. And had been reassured that the consultant had full knowledge of their circumstances. The pre-registration pharmacist had used this intervention as part of her learning. The pharmacy had appropriate written information to give to people. The pharmacy had a SOP for higher-risk medicines such as lithium and methotrexate. And the pharmacy was conducting a lithium audit at the time of the inspection.

The pharmacy dispensed medicines into multi-compartment compliance packs to help approximately

120 people take their medicines. It supplied some packs every four weeks, others on a weekly basis and one pack on a daily basis. This was dependent on need. The team members dispensed four weeks at a time to effectively manage the workload and reduce the risk of errors by dispensing under pressure each week. But the pharmacy didn't have prescriptions for the four packs at the time of dispensing. So as there was no prescription to refer to there was an increased risk of error if people's medicines changed. The ACT worked to mitigate this risk as she had a robust process of checking the medicines in each pack weekly against a valid prescription before they were released for supply. The ACT managed the organisation of the supply of the medicines in the packs. And two dispensers supported her by dispensing the medicines into the packs and following up on queries. The pharmacist completed the clinical check of the prescriptions and the ACT the accuracy check. The service was well organised with audit trails to monitor the ordering and receipt of prescriptions and the dispensing of the packs. The ACT monitored the collection and delivery of the packs, according to a documented schedule. She was very knowledgeable about the whole end to end process. And about the people receiving their medicines in packs. The dispensers and the ACT were seen working well together sorting out queries and contacting the surgery about prescriptions during the inspection. The pharmacy held record sheets for each person detailing their current medication and times of administration. And it had medication diary sheets that the team members completed with any changes, detailing who they had spoken to and the date. The pharmacy supplied patient information leaflets (PILs) each month. The dispenser annotated the pack with descriptions of what the medicines looked like, in case of queries.

The pharmacy provided a delivery service. And the drivers obtained signatures from people for the receipt of their medicines. Once dispensed and checked the pharmacy stored the prescriptions to be delivered in an orderly manner in totes. These were situated on shelves in a separate area of the dispensary. The pharmacy produced a delivery sheet, so it was clear which deliveries were to be made and when. There was a copy of this sheet kept in the pharmacy in case of queries and the original was used by the drivers. The drivers asked people to sign blank labels rather than the sheet, so other people's confidential information couldn't be seen. The drivers were clear why they had been asked to do this. The pharmacy had two drivers working, one in the morning and one in the afternoon. And the two drivers had handover time to ensure any relevant messages were passed on.

The Pharmacy (P) medicines were stored behind the pharmacy counter and some behind Perspex, so the pharmacist could appropriately oversee sales. The pharmacy had a barrier in between the retail area and the dispensary to prevent unauthorised access into staff only areas. So, medicines were kept securely. The pharmacy obtained medicines, medical devices and unlicensed specials from licensed wholesalers. The pharmacy stored its medicines requiring cold storage in medical fridges and kept a daily record of fridge temperatures. The records showed the fridge temperature was kept within the required range in both fridges in the dispensary. There were a couple of missed entries, which could have delayed taking appropriate action if the temperature had deviated from the required range. The fridges were full of stock and kept fairly well organised. The CD cabinet was full of stock, meaning that different strengths and forms could not be easily separated. And it was difficult when checking the stock balance to easily identify if there was additional stock in the cabinet. The team stored different forms of methadone separately and patient returned CDs were kept separate in the cabinet. The pharmacy team had a date checking schedule and used coloured stickers to highlight short-dated stock. One dispenser held the responsibility to ensure the date checking was completed according to the schedule. No out-of-date medicines were found on shelves or in drawers in the dispensary from the sample checked. The pharmacy team annotated the packs of liquid medication with the date opened, to ensure the medicine was fit for purpose when used. The pharmacy had medicinal waste bins available for returned medication.

The pharmacy was compliant with the Falsified Medicines Directive (FMD). The team members used

scanners as part of the dispensing process. They produced barcodes for repeat prescriptions, so the medicines could be decommissioned on handout. And when people waited for their prescriptions the team member usually decommissioned the medicine on the system during dispensing. The ACT kept the manufacturer's packs to one side when checking the compliance packs so the medicines could be decommissioned later. This meant that it was an additional task to complete. The pharmacy had appropriate processes to action medicine recalls and safety alerts.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs for the services it provides. It maintains its equipment to the required standard and uses it in a suitable way to protect people's privacy.

Inspector's evidence

The pharmacy had equipment suitable for the services provided. It had resources available such as the British National Formulary (BNF) and access to the internet to obtain up-to-date clinical information. The electrical equipment was next due for safety testing in April 2020. The pharmacy had two fridges in the dispensary that were in good working order. The pharmacy team used a range of glass, crown stamped measures for measuring liquids. And clean triangles for counting tablets.

The pharmacy stored people's medicines awaiting collection in the front dispensing area. People's details on the medicine's bags could not be seen from retail area. The computers were password protected. And they were positioned in a way to prevented disclosure of confidential information. It held its private information in the dispensing areas. The pharmacy had cordless telephone handsets. These allowed the team members to have telephone conversations in private areas of the dispensary. The pharmacy team members used individual NHS smartcards to access people's medication records. This helped to keep people's confidential medical information 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.