General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Devonport Pharmacy, 51 Damerel Close, Plymouth, Devon, PL1 4JZ

Pharmacy reference: 9010074

Type of pharmacy: Community

Date of inspection: 29/04/2019

Pharmacy context

The pharmacy is located in the Cumberland Centre in Plymouth, adjacent to a minor injuries unit, a GP practice and a dental practice. The pharmacy dispenses NHS and private prescriptions. The pharmacy delivers medicines to people. It also supplies multi-compartment medicines devices for people to use in their own homes. The pharmacy offers advice on the management of minor illnesses and long-term conditions. It also offers flu vaccinations, a minor ailments scheme and drug user services.

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	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 generally identifies and manages risk appropriately. Team members record their errors and review them. But they do not record enough detail to identify patterns of errors. So it is difficult to formulate clear actions to prevent them from happening again. The pharmacy has written procedures in place for the work it does. The pharmacy asks people for their views and acts suitably on the feedback. The pharmacy has adequate insurance to cover its services. The pharmacy keeps the records required by law.The pharmacy keeps people's private information safe and explains how it will be used. Pharmacy team members know how to protect the safety of vulnerable people and act to do this when needed.

Inspector's evidence

The pharmacy had processes in place to manage and reduce risk. Near misses were recorded on a paper log. Detail of records were limited to a cross against the type of error. No further details about the drug or the dispenser were recorded. The pharmacy had a robotic dispenser and it was seen that errors were mainly limited to quantity errors or labelling errors. The technician manager generally reviewed the near misses monthly, although no reviews had taken place for several months. The actions on the last review had included team members double checking the quantity dispensed before passing to the pharmacist for a final check. Team members were also told to clearly mark split boxes with the quantity remaining before they were placed back into the robotic dispenser.

Dispensing incidents were reported to the company head office and contained a more detailed analysis of the cause. Standard operating procedures (SOPs) were held on the company intranet and reflected current practice. They had been recently updated and staff were in the process of reading the updates. The SOP relating to RP regulations was seen and had been signed by all staff. A dispenser could describe the activities that could not be undertaken in the absence of the RP.

Feedback was obtained by a yearly community pharmacy patient questionnaire (CPPQ) survey. 91% of people said that they were very or extremely satisfied with the service provided. A complaints procedure was available. A complaint about the delivery of medicines had been dealt with appropriately, and the team had reviewed the layout of the checking bench and delivery area.

Professional indemnity insurance was provided by the NPA, expiring 30 November 2019. RP records were appropriately maintained, and the correct RP certificate was conspicuously displayed. Records of emergency supplies, private prescriptions and specials medicines were all in order. Controlled drug (CD) records were maintained electronically and were as required by law. Balances were maintained. A balance discrepancy of Xenidate 18mg tablets was due to be investigated by the owner on the afternoon of the inspection. Records of the supply of methadone were held on the Methameasure system and were in order. Patient returns were recorded in a separate register and were destroyed promptly, and records were kept with two signatures.

All staff had completed training on information governance and GDPR. Patient data and confidential waste was dealt with in a secure manner to protect privacy. But confidential information was not removed or obliterated from patient returned medicines. Confidential information on prescriptions

awaiting collection could not be seen by waiting customers. A privacy policy and a fair data use statement were displayed in the patient area and confidential waste was segregated and disposed of appropriately. NHS smartcard use was appropriate. Verbal consent was obtained from patients prior to accessing their summary care record.

All staff were trained to an appropriate level on safeguarding. The RP and the pharmacy technicians had completed the Centre for Postgraduate Pharmacy Education (CPPE) level 2 safeguarding training. Local contacts for escalating concerns were available. Staff were aware of the signs that would require a referral. The staff gave several examples of escalated concerns.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough staff. Team members are appropriately trained for their roles and they keep their skills and knowledge up to date. Team members suggest and makes changes to improve their services. They communicate well with each other.

Inspector's evidence

Staffing levels were adequate on the day of the inspection and consisted of the RP, an accredited checking pharmacy technician, three pharmacy technicians, one NVQ2 level dispenser and a medicines counter assistant (MCA).

Rotas were completed in advance to plan for absences, which were usually covered rearranging shifts, or by part-time staff increasing their hours. In an emergency, the supervisor would call on support from the two other pharmacies in the small chain.

The team had a good rapport and felt they could manage the workload with no undue stress and pressure. The staff had clearly defined roles and accountabilities which were detailed in standard operating procedures, and tasks and responsibilities were allocated to individuals on a daily basis.

The pharmacy team reported that they were allocated protected time to learn during working hours when needed. Resources accessed included revised SOPs and updated product information from pharmaceutical companies. Staff received regular feedback on their performance and had formal appraisals each year.

The MCA was seen to offer appropriate advice when selling medicines over the counter. She was aware of the restrictions on the sale of products containing pseudoephedrine and gave appropriate counselling on the use of co-codamol. She was observed referring to the pharmacist when she was unsure.

The staff felt able to raise concerns and give feedback to the store manager and the RP, both of whom they found to be receptive to ideas and suggestions. Team members were aware of the escalation process for concerns and a whistleblowing policy was in place. The RP described that he felt supported by the owner and the company head office.

The RP said that minimal targets were set and he could use his professional judgement. He said that he would only undertake services such as MURs that were clinically appropriate.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy provides a safe, secure and professional environment for people to receive healthcare.

Inspector's evidence

The pharmacy was adjacent to a minor injuries unit, a GP practice and a dental practice. A healthcare counter led to the dispensary. The pharmacy had a separate entrance to provide a private area for those people accessing drug user services. This area consisted of a small waiting area and a door to the hatch which was released by pharmacy staff electronically when people buzzed the intercom.

The dispensary was large and well organised. Most stock was stored within the robotic dispenser and was put away promptly following delivery. Items not able to be stored in the robotic dispenser were neatly stored on shelves. These items included bulky items such as creams and liquids, and stock bottles of loose tablets. The layout of the pharmacy allowed for effective supervision of staff and pharmacy activities.

A consultation room was available which was of an appropriate size. It was soundproofed and was locked when not in use. The retail and waiting areas were of an appropriate size and there were plenty of chairs in the waiting area. The pharmacy was light and bright, and temperature was appropriate for the storage and assembly of medicines.The dispensary sink was clean and hand soap was available. Cleaning was undertaken by an employed cleaner twice a week and the pharmacy was clean on the day of the inspection.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy is accessible and advertises its services well. It supplies medicines safely. The pharmacy gives additional advice to people receiving high-risk medicines. But it does not make a record of this to show that this advice has been given. The pharmacy obtains its medicines from reputable suppliers. It stores them securely. It does not have a good process to check that they are still suitable for supply. This increases the risk that out of date medicines could be given to people. The pharmacy delivers prescription medicines safely to people's homes. It keeps records to show that it has delivered the right things to the right people. The pharmacy deals with medicines that people return to it appropriately.

Inspector's evidence

The pharmacy and consultation room were wheelchair accessible. Adjustments could be made for people with disabilities, such as producing large print labels and easy to open caps on bottles. The pharmacy had printed checklists for people to use to help them remember to take their medicines in the past. The manager described a recent consultation with a person who did not speak any English. She used a telephone translation service through the neighbouring GP practice to ensure the person received appropriate treatment and advice. Services provided by the pharmacy were advertised on the outside of the pharmacy and the RP was accredited to provide all promoted services.

A range of health-related posters and leaflets were displayed and advertised details of services offered both in store and locally. The manager described that if a person requested a service not offered by the pharmacy, she would either refer them to other nearby pharmacies or to one of the many services provided on the minor injuries unit. A sign-posting folder was available with details of local agencies and support networks and up-to-date information was accessed on the internet.

Colour-coded baskets were used to store prescriptions and medicines to prevent transfer between patients as well as organise the workload. There were designated areas to dispense walk-in prescriptions and those collected from the surgery. The labels of dispensed items were initialled when dispensed and checked.

Stickers were used to highlight fridge items and CDs in schedule 2 and 3 including tramadol. Prescriptions for schedule 4 CDs were annotated to highlight the 28-day expiry. Prescriptions containing high-risk medicines or paediatric medicines were also highlighted with stickers. The RP described that he checked if patients receiving lithium, warfarin and methotrexate had had blood tests recently, and gave additional advice as needed. Records of results were not made on the patient medication record (PMR). Monitoring booklets were available to be given to those needing them.

The pharmacy had completed an audit of patients of childbearing potential receiving sodium valproate as part of the Valproate Pregnancy Prevention Programme. Two people had been identified who met the eligibility criteria for the pregnancy prevention programme. The pharmacist had discussed the need for adequate contraception whilst taking valproate. Stickers were available for staff to apply to the boxes of valproate products for any potential women of child-bearing age, and information cards present to be given to eligible patients at each dispensing.

Approximately 50 people were supplied with methadone or buprenorphine on instalment prescriptions.

Doses were dispensed weekly using a Methameasure machine. The prescriber was contacted if people did not collect their doses for three consecutive days, or if there were other concerns about a person. As described in principle 3, there was a separate entrance available for people accessing methadone or buprenorphine, which was well managed by the accredited checking pharmacy technician.

Prescriptions containing owings were appropriately managed, and the prescription was kept with the balance until it was collected. Compliance packs for patients based in the community were prepared by the pharmacy. Each pack had an identifier on the front, and dispensed and checked signatures were available, along with a description of tablets. Patient information leaflets (PILs) were supplied each month. 'When required' medicines were dispensed in boxes and the technician was aware of what could and could not be placed in trays. A record of any changes made was kept on the patient information sheet, which was available for the pharmacist during the checking process.

Stock was obtained from reputable sources including OTC Direct, Colorama, Alliance and AHH. Specials were obtained from Quantum Specials. Invoices were retained. The pharmacy did not have the required hardware or software to be compliant with the European Falsified Medicines Directive (FMD) but SOPs had recently been updated to reflect the imminent changes.

Stock held in the robotic dispenser was date checked automatically. Date checking of other items was completed sporadically. No date checking matrix was maintained. No out of date medicines or mixed batches were found.The two dispensary fridges were clean, tidy and well organised and records of temperatures were maintained. The maximum and minimum temperatures were within the required range of 2 to 8 degrees Celsius.

CDs were stored in accordance with legal requirements in two cabinets and in the robotic dispenser. An exemption certificate issued by Devon and Cornwall Police was displayed. Denaturing kits were available for safe destruction of CDs. Expired CDs were clearly marked and segregated in the cabinet. Patient returned CDs were recorded in a register and were stored in the robotic dispenser until they were destroyed.

Logs were kept of deliveries made to patients based in the community with appropriate signatures. Confidentiality was maintained when obtaining signatures. The manager described the process followed in the event of failed deliveries to ensure that patients received their delivery in a timely manner, particularly those considered to be vulnerable.

Patient returned medication was dealt with appropriately. But confidential patient information was not removed or obliterated from patient returned medication. The inspector provided advice to the manager about this. Records of recalls and alerts were seen and were annotated with the outcome, the date and who had actioned it.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy uses appropriate equipment and facilities to provide its services. It keeps these clean, tidy and maintains them well.

Inspector's evidence

Validated crown-stamped measures were available for liquids, with separate measure marked for the use of controlled drugs only. A range of clean tablet and capsule counters were present, with a separate triangle clearly marked for cytotoxics. The 'Methameasure' machine was flushed through after use and was calibrated before each use.

The robotic dispenser, a CareFusion Rowa, was serviced regularly and the telephone number of a helpline was prominently displayed. The robotic dispenser became jammed during the inspection due to the security features of FMD compliant packs causing two boxes to become stuck together. The manager resolved the jam quickly and efficiently.

Reference sources were available, and the pharmacy could also access up-to-date information on the internet. All equipment, including the dispensary fridges, was in good working order and PAT test stickers were visible and were in date. The dispensary sink was clean and in good working order. Dispensed prescriptions were stored alphabetically in a retrieval system, out of sight of customers. Computers were positioned so that no information could be seen by customers, and phone calls were taken away from public areas.

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.