General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Cledford Pharmacy, 70 Warmingham Lane, Middlewich, Cheshire, CW10 0DJ

Pharmacy reference: 9010113

Type of pharmacy: Community

Date of inspection: 04/06/2019

Pharmacy context

This is a community pharmacy in a residential area on the outskirts of town. It dispenses NHS and private prescriptions and sells a range of over-the-counter medicines. It provides local post office services from the same premises. It provides a prescription collection service from local surgeries. And it delivers medicines to people's homes.
The team supply medicines in multi-compartmental compliance packs. It provides services such as medicines use reviews (MURs), minor ailments, NHS Urgent Medicine Supply Advanced Service (NUMSAS) and seasonal flu vaccination 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 has procedures to identify and manage the risks associated with its services. The pharmacy mostly keeps the records it must by law. And it keeps people's private information secure. The pharmacy team members discuss and learn from their mistakes. They record them, so they can analyse the information to reduce risks in the future. They know how to identify and raise safeguarding concerns, so they can help protect children and vulnerable adults. But it hasn't reviewed all its written procedures recently. So, the team's ways of working may be out of date.

Inspector's evidence

The pharmacy premises comprised of a small shop area with a full-length counter. The consultation room was behind the pharmacy counter. The pharmacy had clear designated areas for post office supplies and pharmacy services. Most of the staff worked between the two areas although the team members did have designated specialities. And some staff didn't work or have the qualifications to provide pharmacy services. The dispensary was to the rear of the premises, with limited bench space.

The pharmacy had a set of standard operating procedures (SOPs) covering the services provided. The team members had read the SOPs since the last review. And most of the team had signed the SOP training record sheets which were kept at the back of each SOP. The driver said she had read the delivery SOP, but her signature wasn't on the training record. The SOPs had been written over a period of time, but some had a preparation date of 2015. This included the dispensing SOPs and the SOP relating to controlled drugs. They had been due for review in 2017 and so the content may be out of date. Some other SOPs, including complaint handling and monitored dosage system (MDS) supply were in date and due for review in 2020.

The team members kept paper records of near miss errors. And they transferred the information to an on-line system at regular intervals. The pharmacist said due to time constraints it was difficult to record all near miss errors, but some errors were recorded each week. This allowed the pharmacists to complete analysis of the information and help to spot any trends. The reasons for the errors were abbreviated as a single letter, so it was easy to record and analyse the information. The key to the abbreviations was documented on the form. The pharmacist used the information to generate a monthly report that was shared with the team members. They didn't have a team meeting together so may miss out on discussing the errors together. But all team members were able to review the report. Errors were discussed openly at the time and when a potential risk was identified. The team had identified that naproxen 250mg and 500mg tablets were in similar looking packaging and they separated the different strengths on to different shelves. Recently the packaging had changed again, and they no longer look similar, so the team had moved the packs back next to each other on the shelf for ease of selection. It wasn't possible to review the information they had regarding reasons for errors and actions taken because the pharmacist manager had taken the data home to review. The team said it was difficult for this to be done during the working day due to workload.

The team logged dispensing errors on a separate form and kept a copy for reference. On the examples seen the team recorded the full details and completed an investigation into why the error happened. There was an example of a hand out error that had happened in one of the other pharmacies relating the adhesiveness of labels. This had been shared with the team members, so they could report any

issues with the labels and be vigilant when handing out medicines to people.

The team members were aware of their roles and responsibilities. They wore badges with their names on. During the inspection there were several examples of team members working competently within their role, giving advice to people in the shop. The team member referred a query concerning the use of paracetamol to children post- vaccination. The pharmacist came to the counter and gave the person some additional advice. The Responsible Pharmacist (RP) notice displayed was incorrect at the start of the inspection but was immediately changed for the correct details of the RP on duty. A dispenser described what could and couldn't be done when the Responsible Pharmacist wasn't signed in or was signed in but absent.

The pharmacy didn't have a notice or leaflet on display in the retail area to tell people how to make a complaint. The team members said people usually discussed their concerns with the pharmacy manager or regular pharmacist in the first instance. And they said they would write down head office details if people wanted to escalate their concerns. The pharmacy asked for people's feedback via an annual questionnaire. And it advertised the results of the most recent survey from 2018- 2019 on the wall in the retail area. The results were positive.

The pharmacy had appropriate professional indemnity insurance.

The pharmacy had a responsible pharmacist record. And most entries were accurate, but sometimes the time the responsible pharmacist ceased their duties was missing. The pharmacy held electronic CD register entries and the records checked met legal requirements. The registers had running balances. And the system had an alert set to remind the team to check the CD balances every 2 weeks. And there was evidence of regular checks. A physical balance check of MST 5mg tablets and Zomorph 200mg capsules complied with the balance in the register. The system alerted the person making the entry if there had been no previous entry for that medication and strength previously. This acted as a check to prevent mistakes. The pharmacy had electronic private prescription and emergency supply records and the samples checked were mostly complete, but the prescriber details were missing on some entries and so didn't meet the requirements. The pharmacy maintained a full audit trail on certificates of conformity for unlicensed medicines as per MHRA record keeping requirements.

The pharmacy had made changes since the introduction of the General Data Protection Regulations (GDPR). It had changed the driver's delivery sheet so other people's private details were not on show when the person signed for their delivery. The driver explained how she made sure that all prescriptions and medication were stored in the back of the van, so people's private details were not on show through the windows. And she always kept the van locked. She kept prescriptions she collected from the surgery in an opaque wallet to make sure people's details were not on show. The pharmacy had a privacy notice displayed in the retail area. The pharmacy team kept confidential waste in separate baskets and then routinely shredded it. This was observed during the inspection.

The pharmacist manager and regular pharmacist had completed Centre for Postgraduate Education (CPPE) safeguarding training Level 2 in 2017. The team members hadn't received any formal training. The driver described the safeguarding concerns she would raise with the pharmacist. And the team could describe concerns they had escalated either to family members or more formally. The team had a poster up in the dispensary with the local safeguarding team contact details and reporting process. This was dated April 2013 so may be out of date. The team said they had used the internet to find the details.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy team has the qualifications and skills to provide the pharmacy services offered. The team members share and manage the workload to provide safe and effective services. The pharmacy team members openly discuss mistakes and share ideas to improve services. They feel comfortable to raise concerns if necessary. They complete some training relevant to their roles, but they don't have a regular training plan to ensure they keep their knowledge up to date.

Inspector's evidence

On duty at the time of the inspection the responsible pharmacist was the regular part-time pharmacist. The pharmacy team members on the day included two full-time and two part-time NVQ Level 2 dispensing assistants and a part-time driver. The driver helped with general administration duties in the pharmacy, such as shredding the confidential waste. The pharmacist manager, who was also the pharmacist superintendent and a second part-time driver were not present on the day. Some staff had dual roles providing pharmacy services and post office services. All the team members working providing pharmacy services had an appropriate GPhC qualification. Other staff members working providing post office services didn't complete any tasks in the pharmacy that required a qualification. The team members were seen managing the workload and they appeared to mostly be up-to-date with the work. The pharmacist regulated the workload for the space available. And she would stop the team completing dispensing activities until she was up to date with the checking, particularly if she had been in the consultation room providing services. This meant that the number of baskets on the bench was kept at a safe level and baskets weren't stored on the floor. The team said the workload had increased, particularly dispensing into multi-compartmental compliance packs. And there was a plan for one of the dispensers to complete an accuracy checking course to help with the workload and free the pharmacist to provide services.

The pharmacist cover was organised locally as far as possible with the pharmacist manager, the employed pharmacist and regular locum pharmacists as needed. The team discussed holidays together and provided cover for each other. There was only one member of the team allowed on holiday at once. The team recorded their holidays on the holiday planner in the dispensary. This was visible to all team members.

The pharmacist helped the team members keep their knowledge and skills up to date. And she would print off information for the team to read. The team had completed training on oral health and one of the dispensers was a healthy living champion. But the pharmacy didn't have a formal or regular training plan. And they didn't document their learning. Training wasn't tailored to individual members of the team. The pharmacist manager had made plans to make the training more complete, but time was a factor with increasing workload.

The pharmacist felt comfortable discussing concerns with the team or the pharmacist manager. And she could also escalate concerns to head office. She felt her concerns would be listened and action taken to resolve them. The pharmacy had a whistleblowing policy, dated June 2018.

The pharmacy set targets for various services including prescription figures and MURs. The pharmacist said the targets would be discussed and she would use her professional judgement as to whether a

service was appropriate.

The pharmacy team members received notice of recalls and safety alerts by email. They took the appropriate action and kept a record which was signed and dated.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises are clean, secure and maintained to the standard required. The pharmacy has a private consultation room, so the team can have conversations with people in private.

Inspector's evidence

The pharmacy premises were secure and maintained to the required standard. Pharmacy and post office services were offered from the same premises. There was clear segregation of these services. The positioning of the counter restricted access to the dispensing area.
Lighting throughout the premises was sufficient. The pharmacy had air conditioning.

The consultation room was adequate for the team to have private conversations with people. It was sited behind the counter and was clearly signposted. There was a key code to access the room. The pharmacist used the room to hold a private consultation during the inspection.

The pharmacy had a staff toilet and handwashing facilities. There was a separate sink in the dispensary. The pharmacy was clean. The shop and the dispensing area were reasonably small. And apart from the toilet facilities there were no additional rooms in the dispensing area. There was limited bench space for dispensing. And this led to the dispensing area looking slightly cluttered at times. But the pharmacy team managed the space to ensure their services were safe.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy is easily accessible to people, including those using wheelchairs. It provides a range of services to meet people's health needs. It advertises its services and promotes healthy living advice, with some positive outcomes to people using its services. It has good procedures when it dispenses medicines into multi-compartmental compliance packs. And the team makes sure people get their medicines when they need them. The pharmacy sources, stores and manages its medicines appropriately to make sure they are safe to use.

Inspector's evidence

The pharmacy had a small car park in front of the premises. And there was parking available on the road. The pharmacy was accessed using a permanent ramp, with a handrail. It had a service ladder in the window detailing the services the pharmacy provided. And it had the opening hours displayed on the door. There was a bell on the outside of the pharmacy if people needed assistance. And it had chairs available for people to use whilst they waited. The pharmacy had a variety of health-related posters and leaflets on display. The pharmacy advertised the availability of the consultation room if people wanted to have a conversation in private.

The pharmacy was a part of the local community Facebook group and it would share the services it provided and any other useful information. There had been positive feedback on the group recommending the use of the pharmacy.

The pharmacy team used baskets during dispensing to keep people's prescriptions and medication together. And it also helped to prevent people's prescriptions from getting mixed up. The team used different coloured baskets to indicate urgency. The team signed the dispensed by and checked by boxes on the dispensing labels to provide an audit trail and to take responsibility for their work. The pharmacy used clear bags for fridge lines. The pharmacy had a variety of stickers available for the team to use. For example, to highlight fridge and CD lines and to highlight on hand out when the pharmacist wanted to speak to the person and give advice. Several bags in the prescription retrieval area had these stickers attached. The team had a system to scan out the prescription bags on collection and delivery, so they had a complete audit trail.

The pharmacy supplied medicines in multi-compartmental compliance packs for approximately 45 people. The pharmacy had good processes for the dispensing and supply of these packs. The pharmacy had a rota displayed above the bench where the dispensing into the packs took place. The rota was split into a 4-week cycle with the names of the people receiving the packs documented in the correct week of supply. Several members of the team worked to provide the service. The team documented on the rota when prescriptions were ordered, received and dispensed to provide an audit of the process and in case of queries. The dispensers annotated the rota at each stage of the process, so it was easy to keep a check on the outstanding workload. The dispensers ordered prescriptions one week in advance so there was time to resolve any queries. Some people received their medicines weekly and some monthly dependent on their need. Each person receiving their medicines in a pack had a record sheet. It detailed current medication taken and times of administration. The dispensers updated the person's record sheet when there were changed to people's medication. And they signed and dated the changes but didn't annotate who at the surgery had authorised the changes. The pharmacy used printed backing

sheets, which included handwritten descriptions of the medicines in the pack, so people could identify them. And the pharmacy supplied patient information leaflets monthly. An assessment of the suitability of a person for this service was completed prior to starting dispensing. The pharmacy had identified a risk in dispensing some of the packs each week, as this put additional pressure on the workload on certain weeks of the cycle. The pharmacy had spoken to the surgery to ask for 4 weekly prescriptions at once, but this hadn't been possible. It is unknown if the prescriptions could be prescribed using electronic repeat dispensing to alleviate this risk. The pharmacy had managed this risk by changing the process. The packs were dispensed and checked weekly and were stored separately until the prescriptions were received. Once the prescriptions were received the pharmacist completed the clinical check and signed and dated the person's record sheet. This was kept in case of any queries. The pharmacy had an up to date SOP, but the process of dispensing weekly packs in advance of the valid prescriptions was not detailed in the SOP, so it wasn't signed off as an agreed process in the pharmacy.

The pharmacy had provided a popular flu vaccination service over the winter. It had completed a flu risk assessment form for disposal of sharps. It had an up to date flu and needle stick injury SOP. And the pharmacy kept copies of the patient group direction (PGD) and the pharmacists' declaration of competency.

The pharmacy delivered medicines to people's homes. The prescriptions for delivery were dispensed in different coloured baskets. And then when they had been checked they were put in a separate tote away from the prescription retrieval area and stock on the shelves. The prescriptions and EPS tokens were held in a separate basket until the deliveries had been completed. The driver described how she always confirmed the person's name at the address and matched it to the name and address on the prescription bag. And she did this even if she delivered to that person every week, as she understood the importance of the check. The pharmacy had updated the delivery sheet, but it hadn't updated the delivery SOP at the same time.

The team members took extra care when dispensing high-risk medicines. And they had stickers to highlight medicine bags in the retrieval area that contained methotrexate and warfarin. The pharmacist said she would provide extra advice and check the person's yellow anticoagulant book. The pharmacist was aware of the requirement of the valproate pregnancy protection programme. They had completed 2 audits and not identified any people that may be at risk and require advice. The team had leaflets and information relating to the advice to give to people. And there was a note where the valproate stock was kept directing team members to the information. But the information and leaflets were out of date. The pharmacist said she would contact the company to get the up to date materials and stickers.

The pharmacy stocked pharmacy only (P) medicines behind the pharmacy counter, which prevented self-selection. And it stored dispensary stock securely away from public access. The pharmacy obtained stock from licenced wholesalers.

The pharmacy stored the CD stock securely as required and in an organised way. And it kept the out of date CD stock separately in bags away from other stock. But it had several bags of out of date stock and the stock checked had expired in February 2018. So, the out of date stock was not destroyed regularly. It had CD denaturing kits available for use.

The medical fridge was reasonably full of stock and prescriptions awaiting collection. It was a little untidy. The pharmacy team recorded the temperature of the fridge daily. And the sample of records checked were seen to be in range. The fridge was in range during the inspection. There was a bottle of milk in the fridge and it wasn't separated from the pharmacy stock. The risks associated with this were discussed during the inspection.

The pharmacy had received equipment including scanners to enable scanning and decommissioning, as required in the Falsified Medicines Directive (FMD). The team were awaiting installation and training, so it could comply with the law.

The pharmacy had a date checking process and a record sheet to evidence which parts of the dispensary had been checked and when. The team members were up to date with the date checking schedule. They kept a list of medicines expiring each month and removed any remaining on the shelves the month before the stock expired. No out of date medicines were found following a sample check during the inspection. Liquid medicines were annotated with the date opened.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy team has access to the equipment it needs to provide its services. It monitors this equipment to ensure it is safe to use and fit for purpose.

Inspector's evidence

The pharmacy team had the use of up to date resources for example hard copies of reference books, including the BNF and the BNF for children. And it had access to the internet.

The pharmacy had a set of ISO and crown stamped measures available for dispensing. The pharmacy had a medical fridge in working order. There was evidence of electrical safety testing, with stickers attached to electrical equipment. The fan had been tested in August 2018.

The computers were password protected. The pharmacy positioned the computers in the dispensary in a way to prevent disclosure of people's private information. The prescription retrieval area was behind the counter and private details on bag labels couldn't be viewed from the shop. The pharmacy team had NHS smart cards.
The pharmacy had cordless telephones, so the team could have private conversations.

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.