General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Cale Green Pharmacy, 145 Shaw Heath, Stockport, Greater Manchester, SK2 6QZ

Pharmacy reference: 9011097

Type of pharmacy: Community

Date of inspection: 09/08/2019

Pharmacy context

This is a traditional community pharmacy situated on a shopping-parade along a busy main road in a semi-rural residential area, serving the local population. It mainly supplies NHS prescription medicines and orders repeat prescriptions on behalf of people. It has a home delivery service and prepares medicines in weekly compliance packs to help make sure people take their medicines safely. The pharmacy also provides other NHS services such as Medicines Use Reviews (MURs).

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	2.1	Good practice	Staff do not feel pressurised when working and complete tasks properly and effectively in advance of deadlines. And the pharmacy reviews its staffing levels so that they remain appropriate.
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 takes some steps to manage its risks. It provides the pharmacy team with some written instructions to help make sure it provides safe services. The team discusses its mistakes so that it can learn from them. And it keeps people's information secure. The team understands its role in protecting and supporting vulnerable people.

Inspector's evidence

The pharmacy had written procedures that had been issued in July 2018, and were scheduled to be reviewed July 2020. They covered most requirements of the responsible pharmacist (RP) regulations. And it had some written procedures for safe dispensing and controlled drugs (CDs), but they did not cover the pharmaceutical assessment of prescriptions, medicine assembly and labelling or checking CD running balances. So, staff might not always work effectively.

The pharmacy's dispensing label design made it difficult to decipher the dispenser's and checker's initials as it caused them to overlap. And the dispenser or checker did not always initial the label, which made it difficult clarifying who was responsible for each prescription medication supplied, as well as investigating and managing any mistakes.

The pharmacy team recorded mistakes it identified when dispensing medicines and it separately addressed each mistake. However, it only kept these records up until the end of May 2019. And most of them did not include much detail such as the medication involved, the type of mistake, or why the team thought each of these mistakes happened. So, the pharmacy had minimal information to help it effectively learn from and mitigate risks in the dispensing process.

The pharmacy team received positive feedback from people who used its services in its last satisfaction survey from August 2018 to October 2018. A public notice explained how patients could make a complaint and staff had read the pharmacy's complaint procedure, so they could effectively respond to them.

The pharmacy had professional indemnity cover for the services it provided. The RP displayed their RP notice so that people could identify them. The pharmacy maintained the records required by law for the RP and CD transactions and maintained its records for CD destructions. It also kept records of specials medications but did not always include details about who it had supplied them to.

The pharmacy kept records of the few private prescriptions it had dispensed, but typically did not record the prescriber's details. The RP could not locate the corresponding private prescriptions and suspected they had taken them off the premises, and they agreed to make sure these were located and returned.

The RP had briefed staff on protecting people's information, but they had not signed any confidentiality agreement. Staff securely destroyed confidential material, used passwords to protect access to electronic patient data, and used their own security card to access people's NHS electronic data. So, it had an audit trail for who had accessed this information. The pharmacy did not complete any data

protection audit or checklist. And there was a small risk of people’s details on their bags of dispensed medicines being seen from the public area, which the superintendent said they would address.

The superintendent, who was the resident pharmacist, had level two safeguarding accreditation. The pharmacy had reported safeguarding concerns to the GP when people were struggling to manage their medication. In some cases, this had led to it dispensing their medicines in compliance packs, which helped them to avoid becoming confused. However, the pharmacy had not assessed the needs of most people using compliance packs, including whether they needed their medication limited to seven day's supply. The pharmacy also had minimal information on these people’s care arrangements such as their next of kin details. So, the team may not have easy access to this information if needed urgently. And the pharmacy did not have its own or know about the local safeguarding board’s procedures.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has recently experienced some changes to the team. But interim measures are in place whilst the new team forms and gains experience, and its workload is manageable.

Inspector's evidence

The staff present were the superintendent pharmacist who was the resident pharmacist, the RP who was a locum pharmacist providing temporary cover, and a new staff member who started last week on a two-week trial with a view to becoming a trainee dispenser. Other staff included a delivery driver.

The pharmacy had responded quickly when two of its dispensers recently left at short notice, and recruited the trainee dispenser and another dispenser. And another full-time dispenser was being recruited in response to it receiving a steadily increasing number of prescriptions. In the interim the superintendent had employed a second pharmacist and an experienced dispenser from another local pharmacy for two days a week to mainly support the compliance pack dispensing service.

The team managed its workload without any obvious difficulties. The team typically had repeat prescription medicines, including those dispensed in compliance packs ready in good time for when people needed them. The pharmacy received most of its prescriptions via the prescription ordering and electronic prescription services, which helped it to increase dispensing efficiency. And the pharmacy had a low footfall, so the team avoided sustained periods of increased workload pressure and it could promptly serve patients.

The pharmacy did not have any formal financial incentives or targets for the volume of services it provided. And it obtained people’s written consent to provide the prescription ordering and electronic prescription services, so it could effectively show they requested these services.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises are clean, secure and spacious enough for the pharmacy’s services. And its design helps provide safe services. It has a private consultation room, so members of the public can have confidential conversations and maintain their privacy.

Inspector's evidence

The level of cleanliness was appropriate for the services provided. The pharmacy had ample space and separate areas for each of its dispensing services, which allowed the staff to dispense medicines safely. And they could secure it to prevent unauthorised access. The consultation room provided the privacy necessary to enable confidential discussion. But its availability was not prominently advertised, so people may not always be aware of this facility.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's working practices generally help make sure people receive safe services. It gets its medicines from licensed suppliers and manages them effectively to make sure they are in good condition and suitable to supply.

Inspector's evidence

The pharmacy opened Monday to Friday 9am to 6pm and Saturday 9am to 1pm. It had a low front door step and staff could see anyone needing assistance entering the premises, so people could easily access the premises.

The pharmacy offered two different repeat prescription ordering options. One enabled people to request their next prescriptions items when collecting their medicines. This helped limit medicines wastage and meant they received their medicines on time. The other option enabled the pharmacy to order all repeat medicines automatically without checking with the patient. The superintendent said that the pharmacy advised these people to contact them if they wished to change their request, and it sometimes checked if these people still needed all their medication when they collected them. But this system meant the pharmacy could supply medicines that people no longer needed.

The pharmacy did not have any written procedures for dispensing higher-risk medicines including anti-coagulants, methotrexate, lithium or valproate. It had completed a check of all people being prescribed valproate, and confirmed it did not have anyone in the at-risk group. It had also checked if people on higher-risk medicines were experiencing any side-effects or interactions during MUR consultations, and if people who collected their warfarin had a recent blood test. However, it did not do this for people on methotrexate, lithium or those who had their warfarin delivered. And the pharmacy did not have the MHRA approved valproate advice booklets or cards to give people in the at-risk group or advise people on fentanyl patches how to use and dispose of their fentanyl patches safely.

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The pharmacy team scheduled when to order compliance pack patients' prescriptions. So, it could supply their medication in a timely manner. The team kept a record of each of these patient's current medication that also stated the time of day they were to take them. This helped it to effectively query differences between the record and prescriptions with the GP surgery, and reduced the risk of them overlooking medication changes. The pharmacy also kept records of verbal communications about medication queries or changes for people using compliance packs. However, these records were not kept in a structured format, so there was a risk of some information not being recorded. And, the team did not label compliance packs with a description of each medicine inside them, which could make it more difficult for people to identify each medicine.

The team used baskets during the dispensing process to separate people's medicines. This helped it to avoid them becoming confused with others and organise its workload. The team most of the time only left a protruding flap on medication stock cartons to signify they were part-used. This could be easily overlooked and could increase the risk of people receiving the incorrect medication quantity.

The pharmacy prepared methadone instalments in divided daily doses before people presented, so provided the service safely. And it had advised any patients who opted for all their instalment to be dispensed in a single bottle about the safety benefits of having them prepared in divided doses. But it did not keep records of this advice.

Several randomly selected dispensed medications indicated that pharmacists had both assembled and checked them alone. The superintendent said that they usually left a mental break between the assembly and checking stage when dispensing alone, which helped to reduce the risk of mistakes not being noticed. However, the RP said that they sometimes assembled and checked medications alone despite a dispenser being available to co-dispensed.

The pharmacy obtained its medicines from a range of MHRA licensed pharmaceutical wholesalers and stored them in an organised manner. It pharmacy had the software and hardware for implementing the Falsified Medicines Directive (FMD). However, it did not check all the stock that had a code, so did not consistently adhere to the FMD.

The pharmacy quarantined date-expired CDs and destroyed its patient-returned CDs using destruction kits. And it disposed of other obsolete medicines in waste bins kept away from medicines stock. So, the pharmacy reduced the risk of supplying its medicines that might be unsuitable. The team suitably monitored the medication refrigerator storage temperatures. Records indicated that the stock had been date-checked in May 2018 and June 2018. And the superintendent recalled that all the stock had been recently checked, but they did not have any corresponding records. Several randomly selected stock medicines had expiry dates from the end of 2019 to 2022, so were in order. The superintendent said that the pharmacy had took appropriate action when it received alerts for medicines suspected of not being fit for purpose. However, it did not keep supporting records, so it could not clearly demonstrate this.

The team used an alpha-numeric system to store its patient's bags of dispensed medication. So, it could efficiently retrieve patient's medicines when needed. And the pharmacist checked the CD prescription issue date at the point they handed out the medication, so the pharmacy made sure it only supplied CDs when it had a valid prescription.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities that it needs to provide its services effectively. And it secures people's electronic information.

Inspector's evidence

The pharmacy team kept the dispensary sink clean. It also had hot and cold running water and an antibacterial hand-sanitiser. So, it had facilities to make sure it did not contaminate medicines it handled. The team had a range of clean measures, including separate ones for methadone. So, it could accurately measure and give patients their prescribed volume of medicine. It also had access to the latest versions of the BNF and cBNF either paperback or online. So, it could refer to the latest clinical information if needed.

The team viewed people's electronic information on screens not visible from public areas. And the pharmacy regularly backed up people's data on its patient medication record (PMR) system. So, it secured people's electronic information and could retrieve their data if the PMR system failed.

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.