General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Thomas Brown Pharmacy, 51 London Road, Stockton Heath, WARRINGTON, Cheshire, WA4 6SG

Pharmacy reference: 1029835

Type of pharmacy: Community

Date of inspection: 21/06/2019

Pharmacy context

This is a community pharmacy in a shopping district of Warrington, Cheshire. The pharmacy sells over-the-counter medicines and dispenses NHS prescriptions. It also dispenses private prescriptions. The pharmacy team offers advice to people about minor illnesses and long-term conditions. And it offers services including medicines use reviews (MURs), flu vaccinations and the NHS New Medicines Service (NMS). It also supplies medicines in multi-compartmental compliance packs to people living in their own homes.

Overall inspection outcome

✔ **Standards met**

Required Action: None

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 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 adequate processes and written procedures to help protect the safety and wellbeing of people who access its services. It keeps the records it must have by law. They generally keep people's private information safe. And the pharmacy team members are well equipped to help protect the welfare of vulnerable adults and children. But it doesn't always review its procedures and keep them up to date. And the pharmacy team members don't always regularly check the records against the stock. So, they may not identify mistakes and be able to rectify them.

Inspector's evidence

The pharmacy had a set of standard operating procedures (SOPs) in place. These provided the team with information on how to perform tasks supporting the delivery of services. The SOPs covered procedures such as taking in prescriptions and dispensing. The team members were seen working in accordance with the SOPs. The pharmacy kept the SOPs in a ring binder. But there was no index, so it was difficult to locate a specific SOP. Some of the SOPs had not been reviewed in several years. For example, the SOP named ‘operating in the absence of a responsible pharmacist’ had not been reviewed since June 2016. The pharmacy defined the roles of the pharmacy team members in some of the SOPs. Not every SOP showed who was responsible for performing each task. Pharmacy team members said they would ask the pharmacist if there was a task they were unsure about. Or felt unable to deal with. It was not clear which team members had read the SOPs relevant to their role.

The pharmacy had a process to record errors that may happen during dispensing. Normally the pharmacist spotted the error and showed it to the team member responsible. The pharmacist was responsible for recording details of the errors in a near miss error log. But the log was not always used, and no entries had been made since January 2019. The pharmacy rarely recorded the reason why an error had happened. The pharmacy did not formally analyse the errors. Although the pharmacist regularly told the team if he had spotted any errors that were repeated. The pharmacy recorded details of dispensing incidents electronically. The team printed off the record for future reference. And the mistakes were reported to the superintendent pharmacist. The team had not had any incidents over the last few months.

The pharmacy had leaflets in the retail area which contained information on how to make a complaint. The pharmacy organised an annual survey to establish what people thought about the service they received. The results of a survey from 2017 was displayed on a wall in the retail area. The team did not know the results of the latest survey. And they could not give an example of how they had improved the service they offered following public feedback.

Appropriate professional indemnity insurance facilities were in place. The responsible pharmacist notice displayed the correct details of the responsible pharmacist on duty. Entries in the responsible pharmacist record complied with legal requirements. The pharmacy kept accurate records of private prescription and emergency supplies.

The team held records containing personal identifiable information in staff only areas of the pharmacy. Confidential waste was placed into a separate bin to avoid a mix up with general waste. The confidential waste was destroyed periodically. A privacy notice was on display.

The responsible pharmacist had completed training via the Centre for Pharmacy Postgraduate Education on safeguarding the welfare of vulnerable people. The team members had guidance available to them to help them manage concerns about protecting the welfare of children. The team members gave several examples of symptoms that would raise their concerns. And they said they would discuss their concerns with the pharmacist on duty, at the earliest opportunity.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy team members have the right qualifications and skills for their roles and the services they provide. They can give feedback to improve services and can raise concerns where necessary. And although they don't have a regular training plan, they continue their learning by reading and also discussing errors that happen during dispensing.

Inspector's evidence

The regular pharmacist was on duty at the time of the inspection and was supported by three pharmacy assistants. Another pharmacy assistant and the delivery driver were not present during the inspection. The pharmacist was supported by at least two team members at any one time. The pharmacy discouraged the team from taking time off during December as this was the busiest period of business.

The pharmacist on duty supervised the team members. And they involved the pharmacist in offering advice to people who were purchasing over-the-counter products for various minor ailments. They carried out tasks and managed their workload in a competent manner. And they asked appropriate questions when selling medicines that could only be sold under the supervision of a pharmacist. The team members accurately described the tasks that they could and could not perform in the pharmacist’s absence. The pharmacy did not provide its team members with a structured training programme. But the team often updated their knowledge and skills. They usually did this in their own time by reading trade press materials and attending events organised by the local pharmacy committee.

The pharmacy was scheduled to organise monthly team meetings. The team members talked about dispensing accuracy, any concerns they may have, they gave feedback and discussed how they could improve the pharmacy’s services. But the meetings did not always take place. The team members said that instead, they discussed common dispensing mistakes amongst themselves immediately after they occurred. They said this helped them ensure they all learned from each other’s mistakes. But there was no system in place to share the learning with team members who were not present at the time. The team had recently separated different types of fluticasone inhalers to prevent them being mixed up during dispensing.

The team members said that they would speak to the pharmacist if they had any professional concerns they wanted to raise. But a whistleblowing policy was not in place. So, the team members may struggle to raise a concern anonymously. The pharmacy did not set the team any specific targets to achieve.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is secure and adequately maintained. It has a sound-proof room where people can have private conversations with the pharmacy's team members.

Inspector's evidence

The pharmacy was professional in its appearance. And was generally clean, hygienic and adequately maintained. Floor spaces were clear with no trip hazards evident. There was a clean, well-maintained sink in the dispensary for medicines preparation and staff use. There was a WC which had a sink with hot and cold running water and other facilities for hand washing. The temperature was comfortable throughout the inspection. Lighting was bright throughout the premises.

The pharmacy had a consultation room which contained adequate seating facilities. The room was located behind the dispensary. People were required to walk through the dispensary to access the room. The team members were aware of the risks to people's confidentiality and they said any confidential documents such as prescriptions were put away before a member of the public was allowed through the dispensary.

Principle 4 - Services ✔ Standards met

Summary findings

People can easily access the pharmacy. And the pharmacy provides an appropriate range of services to help people meet their health needs. And it mostly identifies and manages the risks with its services. The pharmacy team members highlight people taking high-risk medicines and mostly give them extra advice. But they don't always provide people with information leaflets to help them take their medicines safely. The pharmacy generally stores, sources and manages its medicines safely. But it doesn't have a robust date checking process, so there is a risk medicines may not be identified before their expiry date.

Inspector's evidence

The pharmacy could be accessed from the street through a simple push/pull door. The pharmacy advertised the services it offered in the main window. But the pharmacy's opening hours were not displayed. Seating was provided for people waiting for prescriptions. Large print labels were provided on request. The team members had access to the internet. Which they used to signpost people requiring a service the team did not offer. A range of healthcare related leaflets were available for people to select and take away.

Alert stickers were attached to prescriptions to inform the team to issues on hand out. For example, interactions between medicines or the presence of a fridge line or a controlled drug to be handed out at the same time. An audit trail was not used for dispensed medication. And so, it was not possible to know who had dispensed and checked the medication. And it would be difficult to resolve queries or errors. The dispensary had a manageable workflow with separate areas for the team members to undertake the dispensing and checking parts of the dispensing process. Baskets were available to hold prescriptions and medicines. This helped the team stop people's prescriptions from getting mixed up. The pharmacy did not have a procedure in place to highlight dispensed controlled drugs, that did not require safe custody. And so, the team could not ensure that the medicine was not supplied to people after the prescription had expired. Owing slips were given to people on occasions when the pharmacy could not supply the full quantity prescribed. One slip was given to the person. And one kept with the original prescription for reference when dispensing and checking the remaining quantity. The team attempted to complete the owing the next day.

The pharmacy kept basic records for the delivery of medicines from the pharmacy to people. It did not always get signatures from people to confirm they had received their medicines. And so, an audit trail was not in place to help solve queries. A note was posted to people when a delivery could not be completed. The note advised them to contact the pharmacy.

The pharmacy offered people a managed repeat prescription service. The service was designed to allow the team members to order repeat prescriptions on behalf of people. The team members kept full records of what they had ordered for people. And they compared them with the prescriptions when they were issued to ensure they were accurate. The team member contacted the person's prescriber if there were any discrepancies or queries.

The pharmacy often dispensed high-risk medicines for people such as warfarin. And the team members used alert stickers to help identify these people. The pharmacist often gave the person additional

advice if there was a need to do so. But details of these conversations were not recorded on people's medication records. So, the pharmacy could not demonstrate how often these checks took place. INR levels were not always assessed. The team members were unsure about the requirements of the valproate pregnancy prevention programme. And they did not have any information such as leaflets, that they could give to people who met the criteria of the programme. So, people may not be receiving all the information they need about how to take their medicines safely. The team members had identified a person who regularly received valproate from the pharmacy and had met the criteria of the programme. But they could not demonstrate if they had given the person any additional information about the programme. The pharmacist said that he would look into ordering information leaflets about the programme following the inspection.

People could request their medicines to be dispensed in multi-compartmental compliance packs. And the pharmacy supplied the packs to people on either a weekly or monthly basis. The team members were responsible for ordering the person's prescription. And they did this around a week in advance, so they had ample time to manage any queries. And then they cross-referenced the prescription with a master sheet to ensure it was accurate. The team members queried any discrepancies with the person's prescriber. And the team members checked with people if they required any of their other medicines that they didn't receive in the packs. The team members recorded details of any changes, such as dosage increases and decreases, on the master sheets. They dispensed the packs on a bench at the back of the dispensary. This was to make sure they weren't distracted while dispensing. The packs had backing sheets with dispensing labels attached. And these contained information to help people visually identify the medicines. But this information was often not clear. For example, some medicines were described as 'R' for round or 'GR' for green. The team did not routinely provide patient information leaflets with the packs. This is not in line with legal requirements.

Pharmacy only medicines were stored behind the pharmacy counter. The storage arrangement prevented people from self-selecting these medicines. The pharmacy had a date checking schedule to be completed every three months and it used stickers to highlight short-dated stock. The team members were behind and the last check they had completed was in January 2019. Some short-dated stickers were seen on the dispensary shelves. And no out-of-date stock was found during a random check. The team members recorded the date liquid medicines were opened on the pack. So, they could check they were in date and safe to supply.

The team were not currently scanning products or undertaking manual checks of tamper evident seals on packs, as required under the Falsified Medicines Directive (FMD). No software, scanners or an SOP were available to assist the team to comply with the directive. The team had not received any training on how to follow the directive. The pharmacist said he would discuss with the pharmacy owners how the pharmacy could become compliant soon.

Fridge temperatures were recorded daily using digital thermometers. A sample of the records were looked at. And the temperatures were found to be within the correct range. The pharmacy obtained medicines from several reputable sources. Drug alerts were received via email to the pharmacy and actioned. The alerts were printed and stored in a folder. And the team kept a record of the action that it had taken.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy's equipment is clean and safe, and the pharmacy uses it appropriately to protect people's confidentiality.

Inspector's evidence

References sources were in place. And the team had access to the internet as an additional resource. The resources included hard copies of the current issues of the British National Formulary (BNF) and the BNF for Children. The pharmacy used a range of CE quality marked measuring cylinders. And it had tweezers and rollers available to assist in the dispensing of multi-compartmental compliance packs. The fridge used to store medicines was of an appropriate size. And the medicines inside were organised in an orderly manner. Prescription medication waiting to be collected was stored in a way that prevented people's confidential information being seen by members of the public. And computer screens were positioned to ensure confidential information wasn't on view to the public. The computers were password protected. Cordless phones assisted in undertaking confidential 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.