General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Couper & Coulter Pharmacies Ltd., 296 Old Chester Road, Rock Ferry, BIRKENHEAD, Merseyside, CH42 3XD

Pharmacy reference: 1034383

Type of pharmacy: Community

Date of inspection: 05/03/2020

Pharmacy context

The pharmacy is situated amongst other retail shops in Rock Ferry, near to the town of Birkenhead, Wirral. The pharmacy premises are accessible for people, with adequate space in the retail area. It has a consultation room available for private conversations. The pharmacy sells a range of over-the-counter medicines and dispenses private and NHS prescriptions. It provides a substance misuse service to people, which includes supervised methadone. And it supplies medication in multi-compartment compliance aids for some people, to help them take the medicines at the right time.

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 written procedures to help make sure the team provide services effectively. Members of the pharmacy team are clear about their roles and responsibilities. They know how to protect private information. And they record some things that go wrong. But they do not record or review all their mistakes, so they may miss some opportunities to improve.

Inspector's evidence

There were up-to-date standard operating procedures (SOPs) for the services provided, with sign off sheets showing that members of the pharmacy team had read and accepted them. Roles and responsibilities of the pharmacy team were set out in SOPs. A member of the pharmacy team was able to clearly describe her duties. Dispensing errors were recorded on the incident reporting section of the pharmacy computer. The dispensing errors were reviewed by the pharmacist and shared with the team. Near miss incidents were discussed with the dispenser at the time and some had been recorded in a near miss log. There were several months in the last year with no near miss incidents documented, and no evidence to suggest that the near miss incidents that were recorded had been reviewed for trends or patterns. Pregabalin and gabapentin had been separated on the dispensary shelves following several near miss incidents. The team also provided other examples of stock medication being separated because of the possibility of a dispensing error. For example, similar generic packaging of naproxen and isosorbide mononitrate.

The correct responsible pharmacist (RP) notice was displayed conspicuously in the pharmacy. A complaints procedure was in place. Copies of a practice leaflet were present in the retail area and included information on the complaints process. A member of the pharmacy team explained that she aimed to resolve complaints in the pharmacy at the time they arose, but she would involve the pharmacist if necessary. A customer satisfaction survey was carried out annually. The pharmacist explained that if people were to provide feedback to him about stock availability, he would contact their other pharmacy in the first instance and contact different wholesalers. He explained that the pharmacy had good working relationships with the local GP practices and the GPs would change the medication prescribed when there were long-term manufacturing problems.

A current certificate of professional indemnity insurance was displayed. The private prescription record, emergency supply record, responsible pharmacist (RP) record and the CD register were in order. A balance check for a random CD was carried out and found to be correct. Patient returned CDs were recorded appropriately. The unlicensed (specials) record had the patient details missing from some records.

Confidential waste was shredded. Confidential information was kept out of sight of patients and the public. An information governance policy was in place and team members had read and signed confidentiality agreements as part of their employment contracts. The computers were password protected, with their screens positioned so that they were facing away from customers. Assembled prescriptions awaiting collection were stored so that patient information was not visible. A privacy notice was not displayed. So, people may not know how the pharmacy handles their personal data. The pharmacist had completed level 2 safe guarding training. There were details of local safeguarding contacts present and a safeguarding SOP was in place.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough staff to manage its workload safely. Team members feel able to act on their own initiative and use their professional judgement. They get the basic training they need for the jobs they do. But they do not get any formal ongoing training so their skills and knowledge may not always be up to date.

Inspector's evidence

There was a pharmacist who was a director of the business, a dispenser and a medicines counter assistant on duty. The dispenser and medicines counter assistant had completed accredited training courses for their roles, with their certificates displayed. The usual staffing level comprised of a second medicines counter assistant, in addition to those present. The pharmacy team appeared to work well together and manage the workload adequately.

A member of the pharmacy team said the pharmacist was supportive and was more than happy to answer any questions they had. She explained that she kept up-to-date by talking to the pharmacist and reading any new SOPs, but said no ongoing training material was provided. The pharmacy team were aware of a process for whistle blowing and knew how to report concerns if needed.

The medicines counter assistant was clear about her role. She knew what questions to ask when making a sale and when to refer the patient to a pharmacist. She was clear which medicines could be sold in the presence and absence of a pharmacist and what action to take if she suspected a customer might be abusing medicines such as co-codamol, which she would refer to the pharmacist for advice. The pharmacist explained that there were no targets or incentives set for professional services.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean and tidy. It is a suitable place to provide healthcare. And it has a consultation room so that people can have a conversation in private.

Inspector's evidence

The pharmacy was clean and tidy. It was free from obstructions and had a waiting area. A member of the pharmacy team said that dispensary benches, sink and floors were cleaned regularly, but no record was kept. The temperature in the pharmacy was controlled by heating units. Lighting was adequate.

Pharmacy team facilities included a microwave, kettle, toaster, WC with wash hand basin and antibacterial hand wash. There was a consultation room available which was uncluttered and clean in appearance.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's services are easy to access. And it generally manages and provides them safely. But members of the pharmacy team do not always know when high-risk medicines are being handed out. So, they may not always make extra checks or give people advice about how to take them. The pharmacy team carries out some checks to make sure medicines are in good condition. But it does not always keep records, so it can't show that the checks have been done properly.

Inspector's evidence

The pharmacy, consultation room and pharmacy counter were accessible to all, including patients with mobility difficulties and wheelchairs. There was a selection of healthcare leaflets. The pharmacy team were clear about what services were offered and where to signpost to services they did not provide. The opening hours were displayed near the entrance. The work flow in the pharmacy was organised into separate areas, with dispensing bench space and a checking area for the pharmacist. Baskets were used in the dispensary to separate prescriptions to reduce the risk of medicines becoming mixed up during dispensing.

Prescriptions containing schedule 2 CDs had a sticker included on the assembled bag of medication. The dispenser explained that this was to act as a prompt for team members to take the CD from the CD cabinet and include it with the rest of the assembled prescription at the time of supply. Prescriptions containing schedule 3 or 4 CDs were not routinely highlighted, which may increase the possibility of supplying a CD on a prescription that had expired. Prescriptions with high-risk medicines such as warfarin, methotrexate or lithium were not routinely highlighted prior to collection. The team was aware of the risks associated with the use of valproate during pregnancy. The pharmacy had carried out an audit of patients prescribed valproate and had identified two people who met the risk criteria. The pharmacist had liaised directly with the local care team who informed him that the Consultant who was responsible for prescribing the valproate had discussed the risks with both people. The pharmacy had patient information resources available to supply with valproate.

The pharmacy provided medicines in multi-compartment compliance aids to some people. The dispenser provided an explanation of how the multi-compartment compliance aid service was managed. Details of any changes to medication were added to the pharmacy computer. Disposable equipment was used. Individual medicine descriptions were included on the compliance aid packs and patient information leaflets were provided with each medication supplied.

The pharmacy provided a subtance misuse service to some people. The methadone was dispensed into appropriately labelled medicine bottles in advance of people collecting it or receiving supervised consumption, depending on their prescription. People received the supervision of their methadone consumption in the consultation room or at the screened area of the medicines counter.

The pharmacy offered a prescription delivery service to some people. It kept a delivery record for all prescriptions delivered and people were routinely asked to sign for receipt of their prescription delivery. If a person was not at home when the prescription delivery attempt was made, a note advising them of the failed delivery was left and the prescription medicines were returned to the pharmacy.

Stock medicines were sourced from licensed wholesalers and specials from a licensed manufacturer.

Stock was stored tidily. Date checking was carried out periodically, but no record was kept. A random sample of stock was checked, and a stock container of risperidone tablets was found present that had expired at the end of February 2020. No other expired medicines were found. CDs were stored appropriately. Patient returned CDs were destroyed using denaturing kits. There was a clean fridge used to store medicines, equipped with a thermometer. The minimum and maximum temperature was being recorded daily.

The pharmacy team were aware of the Falsified Medicines Directive (FMD). The pharmacy had a 2D barcode scanner and FMD software installed. And the team were decommissioning FMD compliant medicine packs during the dispensing process. Alerts and recalls were received via NHS, MHRA and wholesaler email notifications. These were actioned on by the pharmacist or pharmacy team member and a record was kept.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide services safely. And it is used in a way that protects privacy.

Inspector's evidence

The pharmacy had copies of the up-to-date BNF and BNFc. The pharmacy team used the internet to access websites for up-to-date information. For example, Medicines Complete. Any problems with equipment were reported to the pharmacist. All electrical equipment appeared to be in working order but there was no record of PAT testing being completed to provide assurance that it was safe.

A dispensette measuring device was used to measure volumes of methadone. It was cleaned and calibrated between use. There was a selection of liquid measures with British Standard and Crown marks. The pharmacy had equipment for counting loose tablets and capsules, including tablet triangles. The computers were password protected with the screens positioned so that they were not visible from the public area of the pharmacy. A cordless telephone was available for private conversations with people.

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.