General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: McDonnell's Pharmacy Ltd, 101 Broad Lane, Norris Green, LIVERPOOL, Merseyside, L11 1AD

Pharmacy reference: 1034421

Type of pharmacy: Community

Date of inspection: 26/06/2019

Pharmacy context

The pharmacy is located next door to a GP Medical Centre in a residential area. The pharmacy premises are easily accessible for people, with an automated entrance door and adequate space in the retail area. The pharmacy sells a range of over-the-counter medicines and dispenses both private and NHS prescriptions. The retail area of the pharmacy was divided in two, with a post office counter situated on one side and the pharmacy counter on the other side. The post office was owned and operated by the pharmacy owner.

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 aims to identify and manage risks associated with its services. Members of the pharmacy team are clear about their roles and responsibilities. The pharmacy generally keeps all of the records it needs to by law. Members of the pharmacy team record things that go wrong, so that they can learn from them. But they do not record all of their mistakes, so they may miss some opportunities to learn.

Inspector's evidence

There were Standard Operating Procedures (SOPs) for the services provided, with signature sheets showing that members of staff had read and accepted them. The SOPs had last been reviewed in 2014 to 2015 according to the review dates stipulated. So, the pharmacy team may not be following the most up-to-date procedures if processes have changed since the last SOP review. Roles and responsibilities of staff were set out in SOPs. A dispenser was seen to be following the SOPs that were relevant to her role and she was able to clearly describe her duties.

The accuracy checking pharmacy technician (ACPT) explained that she was provided with verbal confirmation from the pharmacist that a prescription had been clinically checked and it was ok for her to accuracy check. But this was not recorded so there may be a possibility of the ACPT checking a prescription that had not been clinically assessed by a pharmacist.

Dispensing incidents were recorded on the computer system and learning points were included. The pharmacist demonstrated that because of a dispensing error with sertraline and sildenafil, the stock had been separated. The pharmacist said near miss errors were discussed with the pharmacy team member at the time but were not recorded.

The correct responsible pharmacist (RP) notice was displayed in the pharmacy. A complaints procedure was in place. The pharmacist explained that he aimed to resolve complaints in the pharmacy at the time they arose and said he could not recall the last time he had dealt with a complaint.

A customer satisfaction survey was carried out annually. The pharmacist explained that because some patients had highlighted they were unhappy with issues around stock availability, he would contact wholesalers and speak with the patients GP to request an alternative medication be prescribed if necessary.

The company had appropriate professional indemnity insurance in place. The private prescription record, emergency supply record and the CD registers were in order. Patient returned CDs were recorded. The unlicensed specials record had the patient details missing from some records. The responsible pharmacist (RP) record had the time the RP ceased their duty missing from most entries.

Confidential waste was shredded. Confidential information was kept out of sight of the public. The staff had signed confidentiality agreements as part of their employment contracts. Computers were all password protected and faced away from the customer. Assembled prescriptions awaiting collection were being stored in the pharmacy in a manner that protected patient information from being visible to people. The pharmacist explained that the NHS information governance (IG) toolkit was completed on an annual basis.

The pharmacist said he had completed level 2 safe guarding training. A safeguarding SOP was in place. The local contact numbers required for raising safe guarding concerns were not available in the pharmacy, which may make it more difficult for the pharmacy team in the event of a concern arising.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough staff to manage its workload safely. The team members are trained and work well together. They are comfortable about providing feedback to the pharmacist. The pharmacy enables its team members to act on their own initiative and use their professional judgement, to the benefit of people who use the pharmacy's services.

Inspector's evidence

There was the superintendent pharmacist, an accuracy checking pharmacy technician (ACPT), a dispenser and a medicines counter assistant on duty. The staff were kept very busy providing pharmacy services but appeared to generally manage the workload adequately.

The ACPT explained that she felt well supported by the pharmacist and she was provided with informal feedback from him, an example being around near miss errors. She said that she had not received a performance appraisal. The pharmacist explained that there was no formal ongoing training in place for the pharmacy team. The lack of a regular training programme might restrict the ability of staff to keep up to date. The staff were aware of a process for whistle blowing and knew how to report concerns about a member of staff if needed. i.e. they would speak to the pharmacist in the first instance.

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 was clear what action to take if she suspected a customer might be abusing medicines such as co-codamol. i.e. she would refer the patient to the pharmacist for advice. The pharmacist explained that there were no specific performance targets or incentives set.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean and generally tidy. It is a suitable place to provide healthcare.

Inspector's evidence

The pharmacy was clean and generally tidy. It was free from obstructions and had a waiting area. The dispenser said that dispensary benches, the sink and floors were cleaned regularly. The temperature in the pharmacy was controlled by air conditioning units. Lighting was adequate. The pharmacy premises were maintained and in an adequate state of repair. Maintenance problems were reported to the pharmacist and dealt with.

Staff facilities included a microwave, toaster, kettle, fridge and WC with wash hand basin and antibacterial hand wash. There was a consultation room available which was clean in appearance. The entrance door to the consultation room had a small clear glass panel in it, which may increase the possibility of a breach to patient confidentiality when services were provided.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's services are easy to access, and they are generally well managed. But the pharmacy does not always highlight high-risk medicines, which means people may not always receive advice about taking them. The pharmacy carries out some checks to help make sure that medicines are kept in good condition. But it does not have a record of expiry date check or fridge temperature checks, so, it cannot show that all medicines have been stored appropriately.

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 in the retail area. Staff were clear about what services were offered and where to signpost to a service if this was not provided, for example influenza vaccinations.

The work flow in the pharmacy was organised into separate areas, with a designated area upstairs for assembly of MDS, adequate dispensing bench space and checking areas for the pharmacist and ACPT. Baskets were used to separate prescriptions to reduce the risk of medicines becoming mixed up during dispensing.

A dispenser explained that schedule 2 CDs awaiting collection had a CD sticker attached to the bag. She explained that this was to act as a prompt and ensure that it was not handed out after 28 days of the prescription date. The ACPT said that schedule 3 and 4 CD prescriptions were not highlighted, but they were left segregated in the dispensary until collection. An assembled prescription for gabapentin had not been segregated and was present in the retrieval area, which meant there was a risk of supplying a CD on a prescription that had expired.

Assembled prescriptions for warfarin, lithium and methotrexate were not routinely highlighted prior to collection. The pharmacist said he was aware of the valproate safety alert but he had not identified any female patients who were prescribed valproate and met the risk criteria. The purple folder containing the supporting counselling materials could not be located during the inspection which meant they may not be able to supply all of the necessary information if valproate was dispensed.

A dispenser provided a detailed explanation of how the MDS service was provided. MDS was organised with an audit trail for changes to medication included on the patients printed list of repeat medicines and the computer patient medication record (PMR) being updated. Disposable equipment was used. The dispenser confirmed that patient information leaflets were routinely included. The assembled MDS packs present had no tablet descriptions included and no dispensing audit trail. So, patients may not be able to easily identify their medicines and in the event of a dispensing error it may not be possible to establish who had dispensed and accuracy checked the medicines.

Stock was stored in an untidy manner in the dispensary and in the MDS assembly area, with some loose blisters of stock medication present on the dispensary shelves. The pharmacist said date checking was carried out regularly and short dated medicines were highlighted. He said a date checking record was in place, but this could not be located. No out-of-date stock medicines were found present from a number that were sampled. The date of opening for liquid medicines with limited shelf life was added to the

medicine bottles.

At least ten full general waste bin bags and fifteen full pharmaceutical waste bins were stored by the stairs and upstairs in the pharmacy. The pharmacist said that waste contractors had been contacted and both the general and pharmaceutical waste should be collected soon.

Patient returned CDs were destroyed using denaturing kits and records made in a designated book. A balance check for Fentanyl 75mcg patches (Osmanil brand) was carried out and found to be correct. There were two clean fridges for medicines, both equipped with internal thermometers. The temperature of both fridges was within normal range. However, there were no up to date fridge temperature records for either of the fridges. The pharmacist said this was because the USB thermometers that were placed in each fridge were either broken or not functioning correctly.

The pharmacist said he was aware of the Falsified Medicines Directive (FMD). He said currently they had no FMD SOP in place, no FMD computer software or scanning equipment. Therefore, the pharmacy was not complying with legal requirements. Drug alerts and recalls were received via email. The pharmacist said they were acted on, but no record was kept. This means the pharmacy was unable to demonstrate that drug alerts and recalls were dealt with in a timely manner.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide the service safely.

Inspector's evidence

The up-to-date BNFc was available. The staff used the internet to access websites for up-to-date information. i.e. BNF and medicines complete. Any problems with equipment were reported to the pharmacist. All electrical equipment appeared to be in working order. According to the PAT test stickers attached, the electrical equipment was tested in March 2019.

There was a selection of liquid measures with British Standard and Crown marks. Designated measures were used for methadone. The pharmacy had equipment for counting loose tablets and capsules, including tablet triangles. Computers were password protected and screens were positioned so that they weren't visible from the public areas of the pharmacy. A cordless telephone was available in the pharmacy and the staff said they used this to hold private conversations with patients when needed.

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.