General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: John Hughes, 225 Breck Road, Everton, LIVERPOOL, Merseyside, L5 6PT

Pharmacy reference: 1034426

Type of pharmacy: Community

Date of inspection: 12/08/2019

Pharmacy context

The pharmacy is located on a busy main road, amongst a wide selection of other retail shops. It is situated in a residential area of Liverpool. The pharmacy premises are easily accessible for people, with adequate space in the consultation room and retail area. The pharmacy sells a range of over-the-counter medicines and dispenses private and NHS prescriptions. A number of people residing in their own homes or care homes receive their medicines in multi-compartment compliance aids.

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 generally identifies and manages risks associated with its services. And it generally keeps all of the records it needs to by law. But occasional details are missing, which could cause ambiguity in the event of a query. Members of the pharmacy team are clear about their roles and responsibilities. But team members do not always record and review their mistakes, so they may miss learning opportunities.

Inspector's evidence

There were up-to-date standard operating procedures (SOPs) for the services provided, with signature sheets showing that members of staff had read and accepted them in the last year. Roles and responsibilities of staff were set out in SOPs. A dispenser was seen following SOPs that were relevant to her role and was able to clearly describe her duties.

The pharmacist explained that dispensing incidents and near miss errors were reported on the near miss error log. The near misses were discussed with the pharmacy team member at the time they occurred. There were no near miss errors reported in July 2019 and the pharmacist explained that perhaps all near miss errors had not been reported during this time. As a result of a near miss error with bisoprolol, the different strengths had been separated in the dispensary stock.

The pharmacist explained that he aimed to resolve complaints in the pharmacy at the time they arose, and he would refer the customer to the superintendent if they felt it was unresolved. There was a complaints procedure in place, but there was no information displayed explaining how complaints would be dealt with. So, patients may be unsure how to raise a concern if they were unhappy with the service received.

A customer satisfaction survey was carried out annually. A dispenser explained that because of a patient providing negative feedback regarding their prescription not being ready when they expected it to be, the patient had been spoken to, to explain the process for requesting a prescription from the pharmacy and the turnaround time of 48 hours to receive the prescription back from the GP practice, prior to dispensing. She said by speaking with the patient after receiving their feedback, it had allowed the pharmacy team to help provide clarity and manage the patient's expectation.

The company had appropriate professional indemnity insurance in place. The private prescription record, emergency supply record and unlicensed specials record were in order. Some CD headers were missing from the CD register. Patient returned CDs were recorded appropriately. The responsible pharmacist (RP) record had the time the RP ceased their duty missing on some occasions. The correct responsible pharmacist (RP) notice was displayed conspicuously in the pharmacy.

Confidential waste was shredded. Confidential information was kept out of sight of patients and the public. An information governance SOP was in place and all staff had read and signed confidentiality agreements. The computers were password protected, facing away from the customer and assembled prescriptions awaiting collection were stored in the dispensary in a manner that protected patient information from being visible. There was no privacy notice displayed. So, patients and the public may be unaware how the pharmacy intended to use their personal data.

The pharmacist had completed level 2 safeguarding training. A safeguarding SOP was in place, which had been read and signed by the staff. And the local contact details for seeking advice or raising a concern were present.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough staff to manage its workload safely. The team members 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. But the lack of formal ongoing training could mean their skills and knowledge may not always be up to date.

Inspector's evidence

There was a regular pharmacist, three dispensers, a medicines counter assistant, a pharmacy student and a delivery driver on duty at the time of inspection. The staff were busy providing pharmacy services throughout the inspection. They appeared to work well together as a team and manage the workload adequately.

The staff spoken to said the pharmacist manager was supportive and was more than happy to answer any questions they had. A dispenser explained that no ongoing training material was provided. A whistleblowing SOP was in place. The staff were aware of the process for whistleblowing and knew how to report concerns about a member of staff if needed.

A dispenser said staff were provided with informal feedback from the pharmacist on an ongoing basis. For example, when a near miss error had occurred. 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, when she would refer to the pharmacist for advice. The pharmacist explained that there were no formal 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. It has consultation room for services and if people want to have a conversation in private. But there is a clear glass window in the door which may increase the possibility of a breach to people’s confidentiality occurring.

Inspector's evidence

The pharmacy was clean and tidy. It was free from obstructions and had a waiting area. A dispenser said that dispensary benches, the sink and floors were cleaned regularly by all staff. The temperature in the pharmacy was controlled by heating 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, kettle and fridge, 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 they are generally well managed. 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 generally stores its medicines appropriately. But it does not keep an up-to-date record of date checking, so it is not be able to show that it regularly checks all its stock.

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 displayed. Staff were clear about what services were offered and where to signpost to a service if this was not provided. For example, needle exchange. The opening hours were displayed near the entrance.

The work flow was organised into separate areas, with an assembly area for multi-compartment compliance aids, dispensing bench space and a checking area for the pharmacist. Dispensed by and checked by boxes were not routinely initialled on the medication labels. So, the pharmacy would not be able to identify who was involved in the dispensing process to learn from dispensing incidents. Baskets were used in the dispensary to separate prescriptions to reduce the risk of medicines becoming mixed up during dispensing.

The pharmacist explained that prescriptions containing schedule 2 CDs had a CD sticker included on the assembled bag. He explained that this was to act as a prompt for staff to take the CD from the CD cabinet and include it with the rest of the assembled prescription at the time of supply. Schedule 3 and 4 CD prescriptions were not currently highlighted, which meant there could be a possibility of supplying a CD on a prescription that had expired.

Assembled prescriptions awaiting collection for warfarin, methotrexate or lithium were not routinely highlighted prior to collection or delivery, so the pharmacy team would not always know when they were being handed out. The pharmacist was aware of the risks associated with the use of valproate during pregnancy. He explained that patients who presented with a valproate prescription and who met the risk criteria would be counselled by him and referred to the prescriber for review. There were no patient information resources for the supply of valproate. The pharmacist said he was not aware of a valproate clinical audit being carried out, which meant they may not be aware of patients currently prescribed valproate who met the risk criteria and may not be able to supply all of the necessary information if valproate was dispensed.

A dispenser demonstrated how the multi-compartment compliance aid service was provided. The service was organised with an audit trail for changes to medication being added to a handwritten individual patient record and the computer patient medication record (PMR) being updated. Disposable equipment was used. Medicine descriptions were not included on the labels so patients may not always be able to identify individual medicines. Patient information leaflets were not routinely provided, so patients may not have the most up-to-date medicines information.

The delivery driver explained how the prescription delivery service was provided to patients. He said at

present patient signatures were obtained for receipt of CDs delivered but not for other prescription deliveries. Therefore, the pharmacy would not have a robust audit trail for the supply for all medicines. The delivery driver said if a patient was not at home at the time of delivery a note was left, and the prescription was returned to the pharmacy.

Stock was stored tidily. Date checking was carried out, but an up-to-date record of this task was not kept. Short-dated medicines were supposed to be highlighted, but some short-dated medicines stock was present and had not been. No out of date stock medicines were present from a number that were sampled. CDs were stored appropriately. Patient returned CDs were appropriately disposed of. A balance check for a random CD was carried out and found to be correct. There was a clean fridge for medicines, equipped with a thermometer. The minimum and maximum temperature was being recorded daily and the record was complete.

The pharmacy was not compliant with the Falsified Medicines Directive (FMD) and staff spoken to were unaware what FMD was. The pharmacist said he was unaware of any timescales from the owner for the pharmacy to comply with FMD. Therefore, the pharmacy was not meeting legal requirements. Alerts and recalls etc. were received via email. These were actioned by the pharmacist or pharmacy team member, but a record was not kept, which means the pharmacy was not able to provide assurance that alerts and recalls were being appropriately dealt with.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

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

Inspector's evidence

The staff used the internet to access websites for up to date information. For example, BNF, BNFc and Medicines Complete. Any problems with equipment were reported to the pharmacist. All electrical equipment appeared to be in working order, but it was not PAT tested for safety.

There were two uncalibrated plastic measures used for measuring some liquid volumes. And these were disposed of by the pharmacist once highlighted. There was a selection of other 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.