General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Euro Chemist, 16-20 Berry Street, LIVERPOOL, Merseyside, L1 4JF

Pharmacy reference: 1034428

Type of pharmacy: Community

Date of inspection: 02/07/2019

Pharmacy context

The pharmacy is located amongst other retail shops, in the city centre of Liverpool. The pharmacy premises are easily accessible for people, with adequate space in the retail area and consultation room. The pharmacy sells a range of over-the-counter medicines and dispenses both private and NHS prescriptions.

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 manages the risks associated with its services. Members of the pharmacy team work to professional standards and are clear about their roles and responsibilities. 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 up to date standard operating procedures (SOPs) for the services provided, with signature sheets showing that members of staff had read and accepted them. Roles and responsibilities of staff were set out in SOPs. The dispenser was seen to be following the SOPs that were relevant to her role and she was able to clearly describe her duties.

Dispensing incidents were reported on incident report forms and learning points were included. Copies of previous report forms were kept filed. The pharmacist said near misses were reported on a near miss log and were discussed with the pharmacy team member at the time. As a result of a near miss error with different strengths of amlodipine, a label to prompt staff to select the correct strength of stock had been attached to the dispensary shelf. It was evident from the near miss log that there were some previous months with no near miss errors reported and the pharmacist said that when locums were employed some errors may not be reported.

The correct responsible pharmacist (RP) notice was displayed prominently in the pharmacy. A complaints procedure was in place. The pharmacist explained that she aimed to resolve complaints in the pharmacy at the time they arose.

A customer satisfaction survey was carried out annually. The pharmacist explained that because some patients had provided negative feedback about aspects of the delivery service. Patients were advised that after two failed delivery attempts they were required to collect the prescription from the pharmacy, which was in accordance with the SOP.

The company had appropriate professional indemnity insurance in place. The private prescription record, emergency supply record, specials procurement record and the CD registers were in order. Patient returned CDs were recorded and disposed of appropriately. The responsible pharmacist (RP) record had the time the RP ceased their duty missing from several entries.

Confidential waste was shredded. Confidential information was kept out of sight of the public. The staff had signed confidentiality agreements that were kept in the information governance file. The NHS IG toolkit was completed online on an annual basis. Computers were password protected and faced away from the customer. Assembled prescriptions awaiting collection were being stored on shelves below the counter in a manner that protected patient information from being visible. The prescription delivery sheet used to obtain patient signatures for receipt of delivery had the name and address details of several patients on, which may increase the possibility of a breach to confidentiality occurring.

Safeguarding SOPs were in place and had been read and signed by the staff. The pharmacist had completed the CPPE level 2 safe guarding training. The contact numbers required for raising safe

guarding children and adult concerns were not available in the pharmacy, which may make it more difficult for staff 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. 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 a pharmacist and a dispenser on duty. The staff were busy providing pharmacy services and appeared to manage the workload adequately. The pharmacist explained that the pharmacist who owned the pharmacy and a second dispenser were off work at the time of the inspection.

The dispenser said the pharmacist was very supportive and she was happy to answer any questions. All staff had signed up with CPPE to access their online training resources and the pharmacist demonstrated this for the dispenser who was present, by logging into her CPPE account. It was evident that the dispenser had completed a GDPR training module in April 2019 and a risk management training module in February 2019. The pharmacist said time for training was provided when the workload permitted.

The dispenser said she was aware of a process for whistleblowing and knew how to report concerns about a member of staff if needed. Staff were regularly given informal feedback from the pharmacist. e.g. about near miss errors.

The dispenser who was covering the counter 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 said there were no performance targets or incentives set for the staff.

Principle 3 - Premises ✔ Standards met

Summary findings

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

Inspector's evidence

The pharmacy was clean and 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 heating units. Lighting was good.

The pharmacy premises were maintained and in an adequate state of repair. Maintenance problems were logged, reported to the owner 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 the pharmacy does not always highlight high-risk medications, 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 and suitable to supply.

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 for customers. Staff were clear about what services were offered and where to signpost to a service if this was not provided. e.g. travel vaccinations.

The work flow in the pharmacy was organised into separate areas – with a designated area for the assembly of multi-compartment compliance aids and a checking area for the pharmacist. The pharmacist said that prescriptions for warfarin, methotrexate or lithium were not routinely highlighted prior to collection.

The pharmacist explained that schedule 2 CDs awaiting collection had a CD date 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. She said that schedule 3 and 4 CD prescriptions awaiting collection were not highlighted in the same manner, which meant there was a risk of supplying a CD on a prescription that had expired.

The pharmacy had patient information resources for the supply of valproate, including, patient cards, patient information leaflets and warning stickers. The pharmacist said she had not identified any patients prescribed valproate who met the risk criteria. The pharmacy team had been made aware of the valproate alert.

The compliance aids assembly area was clean and tidy. The dispenser explained how the multi-compartment compliance aids service was provided. The compliance aid was organised with an audit trail for changes to medication added to the handwritten list of medications and the patient medication record (PMR) on the computer being updated. Disposable equipment was used. The dispenser explained that patient information leaflets were not routinely included and were provided when new medicines were commenced. The assembled compliance aids awaiting collection had no tablet descriptions included and no patient information leaflets. So, patients may not be able to easily identify their medicines and may not have the most up-to-date medicines information.

Dispensed by and checked by boxes were initialled on the medication labels to provide an audit trail. Baskets were used in the dispensary to separate prescriptions to reduce the risk of medicines becoming mixed up during dispensing.

The pharmacist explained how the prescription delivery service was provided which was in accordance with the SOP. She provided copies of previous delivery sheets that demonstrated that patient signatures were obtained for receipt of all prescription deliveries. She said a note was left if a patient

was not at home and the prescription was returned to the pharmacy.

Stock was stored tidily in the pharmacy but there were some loose blisters of medication and a small number of medicines that had been decanted from their original containers into medicine bottles and had no batch number or expiry date on. The pharmacist immediately disposed of these medicines and said that she will speak to the pharmacy team to ensure stock medicines were not kept in this manner in future. Date checking was carried out and documented. Short dated medicines were highlighted. No out of date stock medicines were seen from a number that were sampled. The date of opening for liquid medicines with limited shelf life was seen added to the medicine bottles.

CDs were stored appropriately. Patient returned CDs were destroyed using denaturing kits and records made in a designated book. A balance check for a random CD was carried out and found to be correct.

The pharmacist said she was aware of the Falsified Medicines Directive (FMD). She said currently they had no FMD SOP in place, no FMD computer software or scanning equipment. She said that the PMR was due to be updated on 10 July 2019 and the new system would allow the pharmacy to become FMD compliant. Therefore, the pharmacy was not currently complying with legal requirements.

Alerts and recalls were received via email. These were acted 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 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. e.g. BNF and medicines complete.

There were two clean fridges for medicines, both equipped with thermometers. The minimum and maximum temperatures were being recorded daily and the records were complete. The temperature of both fridges was in normal range at the time.

Any problems with equipment were reported to the pharmacist. All electrical equipment appeared to be in working order but was not PAT tested.

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 and a Kirby KL9A electric tablet counter.

Computers were password protected and screens were positioned so that they weren't visible from the public areas of the pharmacy.

A telephone was available downstairs 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.