General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Banks Pharmacy, 15 Church Road, Banks, SOUTHPORT, Merseyside, PR9 8ET

Pharmacy reference: 1034656

Type of pharmacy: Community

Date of inspection: 16/09/2019

Pharmacy context

This is a community pharmacy near a GP's practice. It is situated in the rural village of Banks, near Southport. The pharmacy dispenses NHS prescriptions, private prescriptions and sells over-the-counter medicines. It also provides a range of services including seasonal flu vaccinations and emergency hormonal contraception. A number of people 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 team follows written procedures, and this helps to maintain the safety and effectiveness of the pharmacy's services. They are given training so that they know how to keep private information safe. Members of the team generally record things that go wrong and discuss them to help identify learning and reduce the chances of similar mistakes happening again. The pharmacy keeps the records it needs to by law.

Inspector's evidence

There was a set of standard operating procedures (SOPs) which were reviewed by the superintendent (SI) in July 2018. Their stated period of review of every 12 months had not been completed. So they may not always accurately reflect current practice. The pharmacy team had signed to say they had read and accepted the SOPs.

Dispensing errors were recorded electronically and submitted to the superintendent (SI). The most recent error involved the incorrect supply of felodipine 2.5mg MR tablets instead of felodipine 5mg MR tablets. The pharmacist had investigated the error, recorded it on the NRLS website and made the pharmacy team aware of it. Near miss incidents were recorded on a paper log and the records were reviewed monthly by the pharmacist. The reviews contained little detail about specific risks that had been identified or the actions taken in response. The number of errors recorded in August were lower than previous months and the pharmacist said she did not think everything had been recorded. So some learning opportunities may have been missed. The pharmacist would also highlight mistakes to staff at the point of accuracy check and ask them to rectify their own errors. Examples were provided of action that had been taken to avoid repetition, such as segregating captopril and carvedilol tablets. The company shared learning between pharmacies by email messages. Amongst other topics they covered common errors and similar packaging. The pharmacy team would discuss the information when it was received.

Roles and responsibilities of the pharmacy team were described in individual SOPs. The trainee counter assistant was able to describe what her responsibilities were and was clear about the tasks which could or could not be conducted during the absence of a pharmacist. Staff wore standard uniforms. The responsible pharmacist (RP) had their notice displayed prominently. The pharmacy had a complaints procedure and a notice in the retail area advised people they could discuss any concerns or feedback with the pharmacy team. Complaints would be recorded and followed up by the pharmacist manager or the SI. A current certificate of professional indemnity insurance was on display in the pharmacy.

Controlled drugs (CDs) registers were maintained with running balances recorded. The balance of morphing 10mg MR tablets and Fentanyl 25mcg Patches were checked and both found to be accurate. Patient returned CDs were recorded in a separate register. Records for the RP, private prescriptions, emergency supplies and unlicensed specials appeared to be in order.

An information governance (IG) policy was available. The pharmacy team said they had read the policy and had signed confidentiality agreements. When questioned, the dispenser was able to describe how confidential waste was segregated using the on-site shredder. A privacy notice was on display in the retail area and described how patient data was handled by the company.

Safeguarding procedures were included in the SOPs. The pharmacist said she had completed level 2 safeguarding training. Contact details of the local safeguarding board were also available. The dispenser said she would initially report any concerns to the pharmacist on duty.

Principle 2 - Staffing ✔ Standards met

Summary findings

There are enough staff to manage the pharmacy's workload and they are appropriately trained for the jobs they do. Members of the pharmacy team complete some additional training to help them keep their knowledge up to date.

Inspector's evidence

The pharmacy team included a pharmacist manager, two dispensers – one of whom was in training, two medicine counter assistants (MCA) – one of whom was in training, and a driver. The pharmacy team were appropriately trained or on accredited training programmes. The normal staffing level was a pharmacist and two to three members of staff. The volume of work appeared to be managed. Staffing levels were maintained by part-time staff and a staggered holiday system. Relief staff from nearby branches could also provide assistance.

Members of the pharmacy team completed some additional training, for example they had recently completed a training pack about Children's oral health. But further training was not provided in a structured or consistent manner, and records were not always kept. So learning needs may not always be fully addressed.

The trainee MCA had recently commenced her employment. She said she felt a good level of support from the pharmacy team and felt able to ask for help. She referred any requests for over-the-counter medicines to the pharmacist to ensure they were appropriate. The pharmacy team was seen to sell medicines using the WWHAM questioning technique. The pharmacist manager said she felt able to exercise her professional judgment and this was respected by the pharmacy team and the company.

Members of the pharmacy team did not receive formal appraisals. So individual learning needs may not always be identified. A dispenser said she would receive regular informal feedback about her work and felt able to ask for help. Staff were aware of the whistleblowing policy and said that they would be comfortable reporting any concerns to the head office. There were targets set by the company for services such as MURs. The pharmacist said she did not feel under pressure to achieve these.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are suitable for the services provided. A consultation room is available to enable private conversations.

Inspector's evidence

The pharmacy was clean and tidy, and appeared adequately maintained. The size of the dispensary was sufficient for the workload. A sink was available within the dispensary. Customers were not able to view any confidential information due to the position of the dispensary and access was restricted by the position of the counter. The temperature was controlled by the use of electric heaters. Lighting was sufficient. The staff had access to a kettle, microwave, separate staff fridge, and WC facilities.

A consultation room was available. To enter the consultation room people had to pass through part of the MDS room, which may increase the risk of a breach in confidentiality. The space was clutter free with a computer, desk, seating, and adequate lighting.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides services which are easy to access. And it manages its services to provide them safely. It gets its medicines from appropriate sources, stores them appropriately and carries out regular checks to help make sure that they are in good condition. But the pharmacy team does not always identify people who receive higher-risk medicines. So it might not always check that the medicines are still suitable, or give people advice about taking them.

Inspector's evidence

Access to the pharmacy was level via a single door and was suitable for wheelchair users. There was also wheelchair access to the consultation room. Various posters gave information about the services offered. Pharmacy staff were able to list and explain the services provided by the pharmacy. If the pharmacy did not provide a particular service staff were able to refer patients using a signposting folder. The pharmacy opening hours were displayed at the entrance of the pharmacy and a range of leaflets provided information about various healthcare topics.

The pharmacy had a delivery service. Deliveries were segregated after their accuracy check and a sheet was ticked by the driver following a successful delivery. Unsuccessful deliveries would be returned to the pharmacy and a card posted through the letterbox indicating the pharmacy had attempted a delivery. CDs were recorded in a carbon copy book for individual patients and a signature was obtained to confirm receipt. Some deliveries were delivered to alternative addresses or posted through the recipient's letterbox. A verbal risk assessment and consent was obtained prior to this, but the arrangement was not always reviewed to make sure it was still appropriate for future deliveries. So there may be a risk that the arrangement could be unsuitable if there had been a change of circumstances.

Dispensed by and checked by boxes were initialled on dispensing labels to provide an audit trail. Dispensing baskets were used for segregating individual patients' prescriptions to avoid items being mixed up and the baskets were colour coded to help prioritise dispensing. Owing slips were in use to provide an audit trail if the full quantity could not be immediately supplied.

Dispensed medicines awaiting collection were segregated away from the dispensing area on a collection shelf using a numerical retrieval system. Prescription forms were retained, and stickers were used to clearly identify when fridge or CD safe storage items needed to be added. Staff were seen to confirm the patient's name and address when medicines were handed out.

Schedule 3 and 4 CDs were highlighted so that staff could check prescription validity at the time of supply. High-risk medicines (such as warfarin, lithium and methotrexate) were not routinely highlighted. So the pharmacy team may not be aware when they are being handed out in order to check that the supply is suitable for the patient. The staff were aware of the risks associated with the use of valproate during pregnancy. Educational material was available to hand out when the medicines were supplied. The pharmacist said she would speak to patients to check the supply was suitable, but there were currently no patients that met the risk criteria.

Some medicines were dispensed in multi-compartment compliance aids. The pharmacy would refer

people to their GP to assess whether it was suitable for them to commence the use of compliance aid. To re-order prescriptions, the pharmacy team would use a separate module on the computer records . But when electronic prescriptions were received, the information in the module could be easily overwritten, without the knowledge of the pharmacy team. So this could lead to inconsistency which could cause confusion. Medication changes were confirmed with the GP surgery. Hospital discharge information was sought and recorded on the PMR. Disposable compliance aids were used. An accuracy checking signature was written onto the compliance aid by the pharmacist, but there was no record to show who had assembled it. This may limit learning opportunities in the event of a query or error. Patient information leaflets (PILs) were not routinely supplied and descriptions of individual medicines were not provided. So people may not be able to identify the individual medicines or have all of the information they need to take the medicines safely.

The pharmacy provided an emergency hormonal contraception service (EHC) via a patient group directive (PGD). A copy of the PGD was seen and in date. Consultations were completed online. This would flag to the pharmacist if the patient did not meet the criteria for the PGD and therefore unable to receive a supply. The nearest sexual health clinic was in Ormskirk, about 12 miles away. The pharmacist said this service enabled people to receive EHC without having to travel or delaying the supply.

Medicines were obtained from licensed wholesalers, with unlicensed medicines sourced from a specials manufacturer. The pharmacy was not yet meeting the safety features of the falsified medicine directive (FMD), which is now a legal requirement. Equipment had yet to be installed due to a technical error. The pharmacy's head office was in the process of resolving the error. So the pharmacy team had yet to commence routine safety checks of medicines. Stock was date checked on a 13-week cycle. A date checking matrix was signed by staff as a record of what had been checked, and shelving was cleaned as part of the process. Short dated stock was highlighted using a sticker and liquid medication had the date of opening written on.

Controlled drugs were stored appropriately in the CD cabinet, with clear segregation between current stock, patient returns and out of date stock. CD denaturing kits were available for use. There was a clean medicines fridge with a minimum and maximum thermometer. The minimum and maximum temperature was being recorded daily and records showed they had been within the required range for the last 3 months. Patient returned medication was disposed of in designated bins located away from the dispensary. Drug alerts were received by email from the head office and from MHRA. The pharmacist would respond and report the action taken to the head office, and these reports were kept to provide an audit trail.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy's team members have access to the equipment they need for the services they provide. And they maintain the equipment so that it is safe to use.

Inspector's evidence

The staff had access to the internet for general information. This included access to the BNF, BNFc and drug tariff resources. All electrical equipment appeared to be in working order. According to the stickers attached, all electrical equipment had been PAT tested in July 2019. There was a selection of liquid measures with British Standard and Crown marks. Separate measures were designated and used for methadone. The pharmacy also had equipment for counting loose tablets and capsules, including tablet triangles, a capsule counter and a designated tablet triangle for cytotoxic medication. Equipment was kept clean by the pharmacy team.

Computers were password protected and screens were positioned so that they weren't visible from the public areas of the pharmacy. A cordless phone was available in the pharmacy which allowed the staff to move to a private area if the phone call warranted privacy. The consultation room was used appropriately; patients were offered its use when requesting advice or when counselling was required.

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.