General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Brown and Francis, 49 Bull Ring, LUDLOW, Shropshire, SY8 1AB

Pharmacy reference: 1036016

Type of pharmacy: Community

Date of inspection: 06/01/2020

Pharmacy context

This community pharmacy is located in the centre of the market town of Ludlow. Most people who use the pharmacy are from the local area. It dispenses prescriptions and sells a range of over-the-counter (OTC) medicines as well as other health and beauty items. The pharmacy provides some medicines in multi-compartment compliance aid packs to help make sure people take them correctly. Most of these packs are assembled at another pharmacy. The pharmacy offers additional services including Medicines Use Reviews (MURs), the Community Pharmacist Consultation Service (CPCS) and blood pressure testing. The pharmacy has a Wholesaler Dealers' License (WDL) and is regulated by the Medicines and Healthcare products Regulatory Agency (MHRA).

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 suitably identifies and manages the risks associated with its services. It maintains the records it needs to by law and keeps people's private information safe. Pharmacy team members are clear about their roles and follow written procedures to help make sure they work effectively and complete tasks safely. And they understand how to raise concerns to help protect vulnerable people.

Inspector's evidence

The pharmacy had a range of standard operating procedures (SOPs) covering operational tasks and activities. A small number of procedures, including those covering the management of out of date controlled drugs (CDs) and the prescription collection and delivery service, were overdue a review. So, they may not always reflect current practice. The procedures defined individual responsibilities and team members accessed them electronically, ticking a box to confirm their understanding. Pharmacy team members demonstrated an understanding of their roles and a medicine counter assistant (MCA) accurately described the activities which were permissible in the absence of a responsible pharmacist (RP). A professional indemnity insurance certificate displayed an expiry date of 31 December 2019, but confirmation was provided by the superintendent pharmacist that the policy had been renewed with no break in cover.

Near misses were recorded using an electronic log. All team members had access to the reporting system and felt comfortable recording and discussing near misses. Only one near miss had been recorded since the end of October 2019 and the pharmacist felt that there may be some near misses which were not captured. So, some underlying trends may not be detected. A dispenser discussed some recent training on 'look alike, sound alike' medicines, but the team were unaware of specific changes made in response to previous near misses. Dispensing incidents were recorded electronically, and entries were reviewed by head office. The pharmacist discussed the action that had been taken in response to a recent incident. Including the use of notes on the pharmacy patient medication record (PMR) system, to help prevent the same mistake from happening again.

The pharmacy had a complaint procedure. But the way in which concerns could be raised was not clearly advertised, so people may not always be aware of how they can make a complaint. The pharmacy had recently sought feedback through a Community Pharmacy Patient Questionnaire (CPPQ). Feedback on pharmacy services was usually positive, but comments had previously been made regarding the availability of a space for private and confidential discussions.

The correct RP note was clearly displayed next to the medicine counter. The RP log was maintained, but there were occasional entries where the time RP duties ceased had not been recorded, so it was not fully compliant. Private prescription and emergency supply records were in order, but entries sometimes used dispensing labels which may be removed or fade over time and could compromise the audit trail. Specials procurement records provided an audit trail from source to supply. The pharmacy CD registers kept a running balance and regular balance checks were usually carried out. A patient returns CD register was available and previous destructions had been signed and witnessed.

Pharmacy team members had completed training on information governance and the General Data

Protection Regulation (GDPR). A dispenser discussed some of the ways in which she would help to protect people's private information. Confidential waste was segregated and removed for suitable disposal and completed prescriptions were filed out of view of the medicine counter. Team members held their own NHS smartcards and appropriate use was observed throughout the inspection.

The pharmacist had completed safeguarding training through the Centre for Pharmacy Postgraduate Education (CPPE) and an NHS safeguarding guide was available in the dispensary. An MCA and the pharmacist both discussed some of the types of concerns that might be identified, and the pharmacist said that she would seek advice from the superintendent pharmacist, prior to raising any concerns.

Principle 2 - Staffing ✔ Standards met

Summary findings

Pharmacy team members work in an open culture. They support one another well and can raise concerns and provide feedback on pharmacy services. Team members hold the appropriate qualifications for their roles and complete some ongoing training to address any gaps in their knowledge.

Inspector's evidence

On the day of the inspection, one of the regular pharmacists was present. The pharmacy employed two regular pharmacists, who split the working week between them. The pharmacy team also comprised of a part-time dispenser, a full-time MCA, who was nearing completion of an accredited training programme, and a trainee team member. The trainee had been in post for approximately five-weeks. She had previously completed some healthcare training in a role held several years ago, but was due to be enrolled on an accredited MCA course to refresh her knowledge, within the relevant GPhC timeframe. A delivery driver was also present for a short period of time. Two further dispensers were not present on the day. Leave was usually planned and approved by the company's head office to help make sure that suitable staffing levels were maintained. Planned leave was usually covered by members of a relief dispensing team. The team were seen to manage the workload adequately on the day, the staffing levels were planned so that more dispensers were present later in the week, when the pharmacy workload increased. There was no backlog in dispensing. The team explained that the Christmas period had been busier but felt that the workload had now returned to the usual level.

Medication sales were discussed with an MCA who explained the questions that she would ask to help make sure that sales of medicines were safe and appropriate. Several suitable sales were also observed during the inspection and concerns were referred to the pharmacist. The MCA identified some medications which may be susceptible to abuse and also demonstrated knowledge of restrictions on the use of other medicines, such as age restrictions on Canestan products.

Team members held the appropriate qualifications for their roles or were completing accredited training. An MCA was provided with time to complete her Buttercups MCA course and team members also completed further learning in work time. This included training modules provided by CPPE, with previous modules covering topics such as child oral health and summer health. Training magazines were also available for team members to read on an ad hoc basis. Ongoing development needs were identified and addressed on a continuous basis. An MCA said that if she asked either of the pharmacists a question, they would often further elaborate on the answer to confirm understanding. And any gaps in team members' knowledge were discussed with the pharmacist at the time the issue was identified.

There was an open dialogue amongst the pharmacy team. Team members were happy to approach one another and both regular pharmacists. They used a communication book to help to disseminate important messages and they were happy to contact company management if they have any concerns. A notice which displayed some targets for MUR and flu vaccinations was displayed in the pharmacy. The pharmacist explained that there could be some difficulties with some targets due to the location of the consultation room. The company's head office was aware of this. The pharmacist used the PMR system to help make sure that services were offered to people for whom they were suitable.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is suitably maintained for the provision of healthcare. It has a consultation room to enable it to provide members of the public with access to an area for private and confidential discussions. But the room is not accessible to people with mobility issues. And the dispensary lacks space, which can impact on overall organisation.

Inspector's evidence

The pharmacy was located inside an old building. Some internal fixtures and fittings which were showing signs of wear and tear, but most of the premises were reasonably well maintained. Any maintenance concerns were reported to a company health and safety manager, who arranged for necessary repair work to be carried out. Cleaning duties were carried out by pharmacy team members and the pharmacy was clean and tidy on the day. The temperature was suitable for the storage of medicines and a thermometer was available to review the temperature during periods of warm weather. There was also adequate lighting throughout the premises.

The pharmacy had a small retail area, which stocked some healthcare-based items and other beauty products. Pharmacy restricted medicines were secured from self-selection behind the medicine counter. In the centre of the retail area was a small padded seating bench, which could be used by people who were waiting for their medicines. Various health promotion leaflets were also displayed throughout.

The pharmacy had a consultation room. This was not clearly advertised from the retail area, so people may not always know that it was available. The room was located off the main retail floor and up two steep staircases, so it may not be accessible to people with mobility issues. To the side of the staircase in the retail area, there was a small corner area which could be used for patient counselling and other discussions. But this area was near to the dispensary and a side entrance to the premises. So, there was a risk that some conversations may be overheard. Where this area was not suitable to use and people were unable to access the consultation room, they were signposted to nearby pharmacies. The consultation room was spacious and suitably maintained, and it had a desk and seating to facilitate consultations and a work bench was sometimes utilised for additional dispensing space.

The dispensary was compact, which may impact on overall organisation. There was a main labelling station and one large work bench. Dispensing took place at one end and the pharmacist used the other half of the bench to carry out accuracy checking. Baskets of prescriptions which were awaiting an accuracy check were stored on the bench, which sometimes limited the space which was available. Team members used a cellar, just off the dispensary to store empty tote boxes to try and limit any obstructions on the floor space. A second dispensing terminal was available for dispensing general repeat medicines and shelving units were available for medicine storage. The dispensary had a sink for the preparation of medicines and cleaning materials were available. The pharmacy had additional storage areas and staff WC facilities which were suitably maintained.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's services are generally accessible and suitably managed so that people receive appropriate care. The pharmacy sources, stores and manages its medicines properly to help make sure that they are fit for supply.

Inspector's evidence

The front entrance to the pharmacy had two steps. A ramp facility was available to help those with mobility issues. The pharmacy also had a step-free side entrance which could be used. Both manual doors were fitted with entrance bells to alert pharmacy team members to people entering the premises. A sticker promoting a hearing loop was displayed on the medicine counter.

There was limited advertisement of the pharmacy's services, so people may not always know what is available. There were some leaflets available on blood pressure testing but a practice leaflet listing other services was not seen on the day. Other health promotion literature was displayed throughout the retail area and people who required other services were suitably signposted. For example, the MCA said people who required needle exchange programmes were directed to another pharmacy in the local area and internet access was available to support signposting, if required. Where possible, records of signposting and referrals were made using the PMR system.

Prescriptions were dispensed using colour-coded baskets to keep them separate and prioritise the workload. Team members signed 'dispensed' and 'checked' boxes on dispensing labels as an audit trail during the dispensing process, they also tried to identify any changes to people's regular medicines, such as newly prescribed medicines and dose changes. These were then highlighted to the pharmacist, who used 'pharmacist' stickers to help make sure that suitable counselling was provided. Prescriptions for high-risk medicines were not always routinely identified so that additional monitoring checks could be carried out. An audit involving a review of people prescribed lithium and valproate was currently ongoing. The pharmacist was aware of the risks of the use of valproate-based medicines in people who may become pregnant. She discussed the counselling that should be provided at the time of the supply and had some awareness of safety literature which was available. Copies of some of the literature could not be located at the time of the inspection. The inspector advised on how further copies could be obtained, if required. Prescriptions for CD were identified to help make sure that supplies were made within the valid 28-day expiry date.

The pharmacy collected repeat prescriptions from local GP surgeries. Repeat orders could only be placed for people who received their medicines in multi-compartment compliance aid packs. Medications for these patients were requested by a dispenser, who kept master records of medications and audit trails to identify unreturned requests. Prescriptions were clinically checked by the pharmacist in branch before being scanned over to another branch of the pharmacy. Once assembled compliance packs were delivered back to the pharmacy in sealed tote boxes, where they were matched with original prescription forms. The compliance packs received used a pouch system. Each section contained the patients details and a list of the medications which were enclosed. Compliance packs were supplied with a backing sheet which contained some descriptions of medicines and the details of any necessary warning labels.

The delivery driver obtained signatures for deliveries which were made to patients. Where signatures could not be obtained, the driver signed confirming delivery. Medications from failed deliveries were returned to the pharmacy and a note was left for the patient.

The pharmacy offered blood pressure testing. An MCA had previous experience of using blood pressure machines and said that a dispenser had also provided her with further training. She discussed readings which would be considered outside of normal parameters and said that concerns were referred to the pharmacist. The pharmacy had conducted a small number of CPCS consultations. The service specifications and Pharmoutcomes manual were available to support service delivery.

Stock medications were sourced from licensed wholesalers and specials from a licensed manufacturer. Stock medications were stored in the original packaging and were generally organised. A date checking schedule was available and team members discussed the date checking process. Procedures required checks to be recorded electronically, this had last been done in August 2019. The pharmacist believed that some date checking had been undertaken since this date but had been recorded on paper. The record demonstrating this could not be located on the day. No expired medicines were identified from random checks. Obsolete medicines were stored in medicines waste bins and a list of hazardous materials, which required segregation was displayed. The pharmacy was not yet fully compliant with the requirements of the European Falsified Medicines Directive (FMD). A scanner had been installed and the pharmacist was aware of trials taking place in other branches, but she was not aware of a timescale for implementation in the pharmacy. Alerts for the recall of faulty medicines and medical devices were received via email and through a company alert system. The system was accessible to all team members and staff believed that an audit trail was usually maintained but they were unable to locate the relevant folder on the day.

CDs were stored appropriately. Expired and returned CDs were clearly segregated from stock and a CD destruction kit was available. Random balance checks were found to be correct. The pharmacy fridge was fitted with a maximum and minimum thermometer. The temperature was checked and recorded daily and was within the recommended temperature range.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide its services and team members use equipment in a way that protects privacy.

Inspector's evidence

The pharmacy had access to paper reference materials including the British National Formulary (BNF) and a Drug Tariff. Internet access was also available for further research. Several glass crown-stamped measures were available for measuring liquids. And counting triangles were available for loose tablets. All equipment appeared clean and suitably maintained. As did the pharmacy's blood pressure monitor.

Electrical equipment was in working order and underwent PAT testing in April 2019. The pharmacy computer systems were password protected and screens were all located out of public view. A cordless phone was available to enable conversations to take place in private, if 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.