General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Burslem Pharmacy, Burslem Health Centre, Chapel Lane, Burslem, STOKE-ON-TRENT, Staffordshire, ST6 2AB

Pharmacy reference: 1037005

Type of pharmacy: Community

Date of inspection: 22/08/2019

Pharmacy context

This is a busy community pharmacy located next to a GP surgery in the town of Burslem, Stoke-on-Trent. Most people who use the pharmacy are patients at the surgery next door and the surrounding area is a mixture of residential and commercial properties. The pharmacy dispenses prescriptions, delivers medicines to people who are housebound and provides multi-compartment compliance aid packs, to help make sure people take their medicines at the right time. The pharmacy sells a small range of over-the-counter medicines and provides several other services, including the supply of emergency hormonal contraception (EHC) and local services for the treatment of urinary tract infections (UTI) and impetigo.

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's working practices are generally safe and effective. It has written procedures to help make sure team members complete tasks effectively and it keeps the records it needs to by law. The pharmacy explains how it uses and processes personal data. Its team members complete training to help make sure they keep people's private information safe and they understand how to raise concerns to help safeguard the wellbeing of vulnerable people.

Inspector's evidence

A full set of standard operating procedures (SOPs) were available. The procedures had been updated within the last two years and defined staff responsibilities. A master record sheet had been signed by team members to confirm that they had read, understood and agreed to the procedures. But the record was sometimes incomplete, so the pharmacy may not always be able to demonstrate that all team members are familiar with the procedures which are relevant to their roles. Through discussion, several team members demonstrated an understanding of their responsibilities and were clear on the activities which were permissible in the absence of a responsible pharmacist (RP). Professional indemnity insurance covering pharmacy services was provided through the National Pharmacy Association (NPA).

Pharmacy team members recorded some of their near misses. No entries had been made for August 2019 and records for other months were limited. A dispenser confirmed that he had been involved in a near miss prior to the inspector's arrival and was aware that he needed to record the details of this. The dispenser reported that the regular pharmacist usually reviewed the near miss log and provided verbal feedback. Records of near miss reviews had been made up until March 2019, but no evidence of a review was available after this date, so the team may not always be able to demonstrate what they had learnt. The inspector was shown some shelf edge labels which had been placed to highlight common 'look alike, sound alike' medicines. However, the shelves had been tidied and rearranged the day before the inspection and this meant that some of the stickers were now out of place. The team agreed to rectify this. The pharmacist, who was also a company director said that he would report any dispensing incidents through the National Reporting and Learning System (NRLS). No records of previous incidents could be located, and the pharmacist was unaware of any recent errors.

The pharmacy had a complaint procedure, the details of which were displayed on a poster near to one of the entrance doors. Complaints forms were also available for people to take away and document their concerns. A registered accuracy checking pharmacy technician (ACT) said that she would refer to the pharmacist, should a person raise a concern to her verbally. The pharmacy sought additional feedback through a Community Pharmacy Patient Questionnaire (CPPQ), which was currently ongoing, and people could also leave reviews online.

The correct RP notice was conspicuously displayed near to the medicine counter. The RP log was generally compliant, but three entries were seen where the time RP duties ceased had not been recorded. Emergency supplies were recorded appropriately, and specials procurement records provided an audit trail from source to supply. Private prescription records were held electronically and contained

the information required by statutory requirements. But the details of the prescriber were sometime inaccurate. Missing details or incomplete entries may create ambiguity and mean that the pharmacy is not always able to show what happened in the event of a query. Controlled Drugs (CD) registers were in order and kept a running balance, regular balance checks were carried out and a patient returns CD register was in use.

The pharmacy was registered with the Information Commissioner's Office and a privacy notice was displayed. Pharmacy team members had signed confidentiality agreements and completed some training on the General Data Protection Regulation (GDPR). They demonstrated an understanding of how they would help to protect people's privacy. This included the suitable segregation and disposal of confidential waste and the appropriate use of NHS smartcards. Completed prescriptions were stored on a retrieval system which was out of view of the medicine counter but was located in a walkway used to access the consultation room. The shelves had sliding doors, which could be closed so that confidential information was not visible if someone was accessing the area. But these were not always routinely used and there were some bulky prescriptions which were stored on the surrounding floor space. This meant that the details of some names and addresses may be visible to members of the public, which could impact on confidentiality. This was discussed on the day. The pharmacist also immediately removed a timetable, which showed the details of weekly prescriptions from a wall in the consultation room once this was identified.

Some members of the team, including the pharmacist had completed safeguarding training. A dispenser provided an appropriate response to a safeguarding scenario which was posed and said that concerns were escalated to the pharmacist. A poster displaying the contact details of local safeguarding agencies was in the consultation room. It was last updated in 2017 and the pharmacist agreed to check that the details were still current.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough staff to manage its current dispensing workload. Team members hold the appropriate qualifications for their roles, they complete additional training to help stay up-to-date and get feedback on their development so that they can learn and improve.

Inspector's evidence

On the day of the inspection, the pharmacist was working alongside a registered ACT and four qualified dispensing assistants. The pharmacist worked one morning each week, with the remaining hours covered by a regular pharmacy manager. It was confirmed that this was the usual staffing level for the day. The pharmacy also employed a delivery driver, who was not present. Leave was planned, and staff submitted request forms for approval by the pharmacy manager. The skill mix and workload were then reviewed to ascertain if cover was required and if necessary team members from other nearby branches provided support. The team were seen to manage the workload adequately and were up to date with current dispensing activities for the week. The pharmacist reported that there was sufficient staff for the volume of dispensing and a pharmacy apprentice was also due to start work in the coming weeks.

Team members were trained for their roles. Two dispensers had completed programmes provided by Buttercups and the NPA, and two others had completed pharmacy apprenticeships through a local college. Some training certificates were displayed but the training credentials of all team members were not seen on the day. There were opportunities for ongoing development. The ACT had recently completed her accuracy checking qualification and one dispenser was due to begin the NVQ3 pharmacy technician course in September. Team development was reviewed through appraisals which were reported to take place annually. The team had access to other training materials to help keep their knowledge up to date. An e-Learning training platform provided a range of modules and a dispenser had recently completed a module on mental health. Time for this was provided in work hours and training certificates were filed for reference. Team members worked within their roles and competence. The sale of OTC medicines was discussed with a dispenser who identified the questions that he would ask to help make sure a sale was safe and appropriate. The dispenser highlighted some medications which may be susceptible to abuse, and concerns were referred to the pharmacist. He also discussed a previous refusal of a sale where frequent requests were being made.

The team worked together closely and were comfortable to raise concerns to both the ACT and the pharmacist. But there were some members of staff who were unsure about how a concern could be raised anonymously if required, but they said the need for this had not arisen. The pharmacist confirmed that no formal targets were set for professional services.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy provides a suitable environment for healthcare. The pharmacy is secure, and it has a consultation room to enable it to provide members of the public with access to an area for private and confidential discussions.

Inspector's evidence

The pharmacy's premises were in a reasonable state of repair. There was some minor exterior damage to one of the windows which may detract from the overall appearance. The pharmacy was based inside an NHS contracted building and the pharmacy paid a maintenance fee for repair work. The pharmacist said that on occasion the response could be slow, but all previous necessary repair work had been completed. Pharmacy team members carried out daily house-keeping duties. The pharmacy was generally clean on the day, but some shelves were slightly dusty. There was adequate lighting throughout the premises and the ambient temperature was appropriate for the storage of medicines. A portable fan was available to assist with temperature regulation.

The retail area stocked a range of suitable healthcare-based goods and pharmacy medicines were restricted from self-selection. The area was generally tidy, with walkways free from obstructions and chairs available for use. The pharmacy had a consultation room, which was accessed from behind the medicine counter. A small notice was displayed advising members of the public that an area for confidential conversations was available. The room was appropriately maintained and was equipped with a desk and seating. It had a storage unit with closed doors to help make sure that confidential information was not visible to people using the room.

The dispensary had sufficient space for the dispensing workload. A large open plan area was used for dispensing. There was an appropriate amount of work bench space to allow for the segregation of dispensing and checking and large shelving units were used for additional storage. The main dispensary had a sink for the preparation of medicines and two further small areas were available for office space and the assembly of compliance aid packs.

The pharmacy also had staff WC facilities which were appropriately maintained but were being used for the storage of consumable items such as bags and capped medication bottles as well as obsolete medicines. This was not appropriate and could negatively impact on the hygiene of these items.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy' services are generally accessible and suitably managed so that people receive appropriate care. It obtains medicines from reputable sources and it carries out some checks to make sure that they are suitable for supply. But it could do more to make sure that people on high-risk medicines receive all the information that they need.

Inspector's evidence

The pharmacy had two entrances from the main street, one located near to the GP surgery entrance had a small step and wheelchair accessible entrance was located on the main street. This was advertised through posters displayed on the door. A notification bell advised staff of entry to the premises. The pharmacy could offer some additional adjustments for people with different needs, such as the use of large print labels from the computer system, to assist people with visual impairment.

There was limited advertisement of the services available from the pharmacy and a current pharmacy practice leaflet was not available on the day, which could mean that people are not always aware of what services are offered. The retail area also had a small health promotion area near to the counter with limited literature available for selection. People who required other services were signposted. The pharmacy had previously kept records of this, but the sheets seen had not been updated since March 2019.

Prescriptions were dispensed using baskets to keep them separate and reduce the risk of medicines being mixed up, and the pharmacy kept audit trails to identify people involved in dispensing and checking. The team discussed how they would highlight prescriptions for high-risk medicines using some stickers which were available. Records of monitoring parameters such as INR readings for people of warfarin were not always kept. The pharmacist discussed that this had already been identified as an area for improvement and was identifying ways to improve recording and monitoring. The team had an awareness of the risks of the use of valproate-based medicines in people who may become pregnant. But they were not always familiar with when safety literature should be provided in line with recent guidance issued by the Medicine and Healthcare products Regulatory Agency (MHRA). This was discussed with the team and the inspector advised on how further resources could be obtained. A single patient alert card was located during the inspection.

Patients requested repeat prescriptions through the pharmacy, who kept a record of requests which were sent off, so that unreturned prescriptions could be identified. The pharmacy team automatically requested medicines for people using multi-compartment compliance aid packs. They only ordered medicines which were placed into the compliance pack and any external and 'when required' items were ordered upon patient request, to help prevent over-ordering. Compliance packs had patient identifying labels and descriptions of medicines were recorded. No high-risk medicines were placed into packs. Delivery sheets were used to obtain patient signatures, to confirm the secure delivery of medicines. There were some records which had not been signed by patients. The pharmacy used additional record sheets for the delivery of CDs and medications from failed deliveries were returned to the pharmacy.

The pharmacist discussed training for some of the other services provided by the pharmacy. This included the completion of some online modules and safeguarding training. Copies of patient group directives (PGDs) were available and consent forms were completed.

The pharmacy sourced medicines through reputable wholesalers and specials from a licensed manufacturer. Stock medicines were stored in an organised manner and in the original packaging provided by the manufacturer. Most liquids were marked with the date on which they were opened, but a bottle of methadone, which had a shortened expiry following opening was not. The team discussed date checking systems and records of recent checks were available. Short-dated medicines were highlighted, and no out-of-date medicines were identified during random checks. Appropriate waste bins were available for returned and expired medicines, but there were several bags surrounding the bin which still needed to be sorted. The pharmacy was not yet compliant with requirements as part of the European Falsified Medicines Directive (FMD). They had registered with SecurMed and a scanner had been ordered. The pharmacist confirmed that SOPs required updating to include the new processes and hoped to become compliant in September 2019. Alerts for the recall of faulty medicines and medical devices were received via an email system, which was checked daily. The pharmacy kept an audit trail showing the action that had been taken in response to alerts received.

CDs were stored appropriately, with out of date and returned medicines segregated from stock. Substance misuse prescriptions were dispensed in advance and were stored in an organised manner. The pharmacy fridge had a maximum and minimum thermometer. It was within the recommended temperature range on the day and a daily temperature record was kept. There were occasional gaps seen in the sample portion viewed, which the pharmacist agreed to review with the team.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide its services safely and it is used in a way that protects people's privacy.

Inspector's evidence

The pharmacy had access to some paper-based reference texts and internet access supported additional research. All equipment seen was appropriately maintained. The counting triangles were clean, glass conical measures were British Standard approved and separate measures were marked for use with CDs.

Electrical equipment was in working order. Computer systems were password protected and the layout of the pharmacy meant that screens were positioned out of public view. Cordless phones also enabled conversations to take place in private.

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.