General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Birches Head Pharmacy, 12 Diana Road, Birches Head, STOKE-ON-TRENT, Staffordshire, ST1 6RS

Pharmacy reference: 1037016

Type of pharmacy: Community

Date of inspection: 13/11/2019

Pharmacy context

This busy community pharmacy is located amongst several other retail units, in a residential area of Stoke-on-Trent. Most people who use the pharmacy are from the local area and there is a GP surgery close by. The pharmacy dispenses prescriptions and sells a range of over the counter (OTC) medicines, as well as other household items including cleaning products and greeting cards. It supplies some medicines in multi-compartment compliance aid packs, to help make sure people take them at the correct time. It also offers several other NHS services including Medicines Use Reviews (MURs), flu vaccines and a substance misuse treatment service.

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	2.5	Good practice	The pharmacy team members provide feedback and raise concerns to help identify areas of improvement in the pharmacy.
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 identifies and manages risks adequately. It asks for feedback on its services and it keeps the records it needs to by law. The pharmacy has some procedures to help make sure it keeps people's private information safe. The pharmacy team members work within their roles and they understand how to raise concerns to help protect vulnerable people. But they could do more to learn from their mistakes and show the action they take to help prevent the same mistakes happening again.

Inspector's evidence

The pharmacy had a set of standard operating procedures (SOPs) covering operational tasks and activities. Some of the procedures had incomplete version controls and others indicated that they were due for review in 2018, so it may not always be possible for the pharmacy to demonstrate that the procedures are up-to-date and that they reflect current practice. The procedures did not always clearly record the responsibilities of pharmacy team members and audit trails confirming staff acknowledgement were incomplete. The pharmacy team members were observed to work within their defined roles and through discussion they demonstrated an understanding of their responsibilities. They described the activities which were permissible in the absence of a responsible pharmacist (RP). Indemnity insurance covering the provision of pharmacy services was provided through Numark.

The pharmacy team members discussed near miss recording. An electronic records system had been introduced in the pharmacy at the beginning of 2019 and in recent months the team had started to use the near miss function of the system. Four entries had been recorded in October 2019 and there were no further records available. The pharmacist said that near miss recording had been highlighted as an area for improvement and he confirmed that some near misses were not recorded. The team had recently reviewed the layout of the dispensary, but they were unsure of any specific changes that had been made in response to near misses or incidents. The team were unaware of any recent dispensing incidents and said that if identified a record would be made using the electronic incident reporting system.

The pharmacy had a complaint procedure, but this was not clearly advertised so people may not always be aware of how they can raise a concern formally. A medicine counter assistant (MCA) said that most people who used the pharmacy were from the local area. She explained that there was a good relationship between pharmacy team members and regular patients and reported that verbal feedback was usually positive. A complaint book did not identify any recent concerns and the pharmacy also participated in an annual Community Pharmacy Patient Questionnaire (CPPQ).

The correct RP notice was clearly displayed. The RP record was available but was not fully compliant as it did not always state the times at which RP duties ceased. Private prescription and emergency supply records were maintained, but some entries for private prescriptions did not record both the date of supply and the date of dispensing. Although all entries were up-to-date on the day, it was identified that team members did not always record the details of private prescriptions within the required timeframe, instead writing them up in batches. This was discussed on the day and the team agreed to

amend this practice moving forward. Specials procurement records provided an audit trail from source to supply. The pharmacy's controlled drugs (CD) registers were generally in order, they kept a running balance and a patient returns CD register was available.

The pharmacy had an information governance folder, but audit trails confirming that team members had read the procedures within it were incomplete and its registration status with the Information Commissioner's Office was not confirmed. Pharmacy team members reported that issues such as confidentiality had been discussed with them verbally. They segregated confidential waste, which was then shredded on the premises and they had access to their own NHS smartcards, several of which were unlocked by a member of the NHS team on the day. One smartcard belonging to a team member who was not present was identified in a computer terminal. This was removed and locked away by the pharmacist on the day but may indicate that cards are not always suitably secured from unauthorised access when not in use. The layout of the pharmacy meant that patients had to enter part of the dispensary to access the consultation room. Due to this they were required to walk past the prescription retrieval shelves, and the names and addresses of patients were visible on prescription bags, which could impact on confidentiality.

The pharmacy team had read some safeguarding information and the pharmacist had completed training through the Centre for Pharmacy Postgraduate Education (CPPE). A MCA discussed some of the types of concerns that might be identified and explained how these would be managed. The pharmacist had not had to raise any previous concerns, but the contact details of local agencies were accessible to enable escalation.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy team members can manage the current dispensing workload. They feel comfortable contributing ideas or raising concerns with the pharmacy management. And the pharmacy acts on this to make improvements to the services. Team members hold the appropriate qualifications for their roles. But they get limited ongoing learning and development. So, the pharmacy may not always be able to show how it identifies and addresses gaps in their knowledge.

Inspector's evidence

On the day of the inspection, the regular pharmacist was working alongside a pre-registration pharmacist, two qualified dispensers, one of whom worked part-time and a MCA. An additional employee was also present, she was currently completing an apprenticeship in customer services through a local college and worked in the retail area of the business. The apprentice was not seen to undertake any pharmacy related activities throughout the inspection. The pharmacy also employed a registered pharmacy technician, who was the pharmacy manager. And additional team members included a newly employed dispenser, an MCA and two delivery drivers, one of whom was present for a short period of time. The team confirmed that the workload in the pharmacy was busy, but usually manageable. And there was no dispensing backlog on the day. The pharmacist said that if required, an additional pharmacist who lived locally and covered some shifts in the pharmacy could provide extra support. The company had been supportive of this when it had previously been requested. Leave was usually planned, and the team worked flexibly to increase their hours and provide cover as needed. They also did this in the event of unplanned sickness. Restrictions were placed on leave to help maintain a suitable staffing level.

Sales were discussed with an MCA who discussed the questions that she would ask to help make sure that they were safe and appropriate. Concerns were referred to the pharmacist and the MCA identified some OTC medications which may be considered more high-risk. This included co-codamol and requests for this were monitored. The MCA had not personally been involved in a refusal of sale but said concerns regarding frequent purchases would be referred to the pharmacist.

Pharmacy team members were trained for the roles in which they were working. The pre-registration pharmacist had a structured training programme for the year, with support provided by Buttercups. He attended regular study days and completed additional work through an e-learning platform. This was monitored by the pharmacist, who was the pre-registration tutor and a course tutor. He was allocated half a day each week for training. The pre-registration pharmacist and the pharmacist both worked full-time hours at the pharmacy and they held regular progress meetings. Structured ongoing training for other team members was limited and protected training time was not provided. The team reported that the pharmacy manager advised them of any training events in the local area and where possible team members would attend, but these often took place outside of working hours. Records of training were not maintained. Recently, the pharmacy manager had introduced training folders for each employee, but nothing had been documented at the time of the inspection. Development was discussed on an ongoing basis. Formal appraisals had not yet been arranged.

There was an open dialogue amongst the pharmacy team. Team members were happy to approach both the pharmacist and the pharmacy manager. They also had regular contact with pharmacy management. In response to staff feedback, there had been some recent work carried out inside the premises to create an additional dispensing area for the assembly of compliance aid packs. The team reported that management were receptive to feedback that they raised and felt comfortable in speaking up to raise issues. The pharmacist confirmed that there were no set targets in place for professional services. He said that services were encouraged where appropriate.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy provides a suitable environment for the delivery of healthcare. It has a consultation room to enable it to provide members of the public with an area for private and confidential discussions. But a step access may mean that this is not always accessible to people with mobility issues.

Inspector's evidence

The pharmacy was in a good state of repair and portrayed a professional appearance. There had been some recent building work which had been completed to nice standard. But this meant that there were some storage areas which were slightly unorganised prior to items being put back in their new locations. Maintenance concerns were escalated to the company's management, so that necessary repairs could be arranged, and pharmacy team members completed housekeeping duties. The pharmacy was generally clean on the day. There was adequate lighting throughout and the temperature was suitable for the storage of medicines.

The front of the pharmacy had a spacious retail area, which stocked a range of household goods, including cleaning products as well as a range of greeting cards. In one corner there was some health promotion literature and there was information on pharmacy opening times and other local pharmacy's in the front window. Chairs were available for use by people waiting for their medicines and pharmacy restricted medicines were secured behind the medicine counter.

The recent changes made to the premises meant that the available dispensing space was suitable. The main dispensary had a front bench with a labelling terminal and a separate area for accuracy checking by the pharmacist. There was an additional labelling terminal on a long and narrow work bench, where the majority of dispensing took place. Prescriptions were then stored in baskets on a third work bench, until they were taken for a final accuracy check. The dispensary had a sink for the preparation of medicines and medicines were stored on large shelving units, which created additional space. The dispensing room recently fitted in the rear of the premises had shelving units for the storage of compliance aid packs and a large work bench was available for prescription assembly.

The pharmacy had a consultation room, situated in the front section of the dispensary. It was accessible from behind the medicine counter and had a single step entry, which may restrict the ability of some people to access the room for a confidential discussion. The room had a desk and seating available and a blind was used for additional privacy. But it was cluttered in places, which may detract from the overall professional appearance.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's services are generally accessible and suitably managed, so people receive appropriate care. But it does not consistently identify prescriptions for high-risk medicines to make sure people get all of the information they need to take their medicines properly. It sources medicines appropriately and has made recent changes to help make sure that it can demonstrate in a more robust manner that medicines are suitably stored and are fit for purpose.

Inspector's evidence

The pharmacy was located in a parade of shops and it had a single-step access to the front. A portable ramp was available to assist with entry, but this was not clearly advertised so people may not always be aware that it was available. The manual door was visible from the medicine counter, so that people requiring assistance could be identified. A bell had previously been fitted, but this had been stolen. Additional adjustments could be made for people with different needs, this included large print labels from the pharmacy's computer system and the pharmacist also discussed how written notes were used to communicate with a patient who was hard of hearing.

There was limited advertisement of the pharmacy's services and a practice leaflet was not available on the day, so people may not always be aware of the services which are available. There was some health promotion literature displayed and the team had internet access to NHS resources to support signposting.

Prescriptions were kept separate using baskets, which were colour coded to prioritise the workload and pharmacy team members kept an audit trail for dispensing by signing 'dispensed' and 'checked' boxes. The pharmacy did not always retain the original prescription forms alongside medicines until the point of collection. This may mean that team members do not have access to important information at the time of supply and may increase the risk of a prescription being claimed in error prior to it being supplied. They said that prescriptions for high-risk medicines would be highlighted using stickers, but audit trails of monitoring parameters were not kept as a record of this. Some members of the team had an awareness of the risks of the use of valproate-based medicines in people who may become pregnant. But some team members were unclear. The guidance issued by the Medicines and Healthcare products Regulatory Agency (MHRA) was discussed with the pharmacist, along with the safety literature required for making supplies. In-date copies of the resources could not be located on the day and the inspector advised on how these could be obtained.

The pharmacy provided a repeat prescription collection service. People contacted the pharmacy to request the medications required and records were kept identifying unreturned prescriptions and discrepancies. People signed a book to confirm the delivery of medicines and additional records were kept for the delivery of CDs. Medications from failed deliveries were returned to the pharmacy and the driver said that he planned his route to make sure that deliveries including fridge items were delivered first.

Multi-compartment compliance aid packs were managed using a four-week system. Pharmacy team members ordered medications which were placed into packs and additional medicines were requested by patients, to help prevent over ordering. Prescriptions were checked against a master record sheet to identify any changes and compliance aid packs contained descriptions of individual medicines and an audit trail for dispensing on a backing sheet. But this was not always securely affixed to the pack, so it may become detached and mean that the pack is unidentifiable. Patient leaflets were not always supplied in line with requirements. This was discussed with a dispenser, who agreed to supply the leaflets moving forward.

The pharmacist had completed training for the provision of the flu vaccine. Certificates were seen confirming training and access was available to the patient group directive (PGD). Equipment to support the delivery of flu vaccines was available, including adrenaline and a sharps bin.

Stock medications were obtained from suitable wholesalers and specials from a licensed manufacturer. Mediations were stored in their original packaging and were generally organised. Some recent date checking had been completed and short dated medicines were highlighted. No expired medicines were identified from random checks. Obsolete medicines were stored in appropriate medicines waste bins and a cytotoxic bin was available for the segregation of hazardous materials. The pharmacy was not yet compliant with the requirements of the European Falsified Medicines Directive (FMD). A new scanner had been implemented but the team were unsure of when the pharmacy would become fully compliant. They received alerts for the recall of faulty medicines and medical devices through an electronic system, which was checked daily.

CDs were suitably stored and expired and returned CDs were segregated from stock medicines. Random balance checks were found to be correct and CD denaturing kits were available. The pharmacy kept stock in two refrigerators, one of which was fitted with a maximum and minimum thermometer and the temperature was checked and recorded each day. The thermometer in the second refrigerator had broken. The refrigerator contained several prescriptions which were awaiting collection and delivery. The pharmacist said that a new refrigerator had been sourced in response to this issue and it had recently been installed in the new dispensing area. On the day, the temperature of the new fridge was within the recommended temperature range. The pharmacist therefore ensured that the stock was relocated on the day and a new temperature record was created, so the pharmacy could demonstrate suitable storage.

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 up-to-date reference materials including the British National Formulary (BNF). Team members could access information through Numark services and a general internet access was also available. The pharmacy had several crown-stamped glass measures for measuring liquids. Separate measures were clearly marked for use with CDs. Loose tablets were counted using counting triangles and separate triangles were marked for use with cytotoxic medicines.

Electrical equipment appeared to be in working order and computer systems were password protected. Screens were located out of view of the medicine counter and cordless phones 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.