General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Eason Pharmacy, 215A Watling Street, Wilencote, TAMWORTH, Staffordshire, B77 5BB

Pharmacy reference: 1037115

Type of pharmacy: Community

Date of inspection: 13/08/2024

Pharmacy context

This independent community pharmacy is located in a residential area of Tamworth. Its main activity is the dispensing of medicines against NHS prescriptions. It provides NHS commissioned services such as Pharmacy First, New Medicine service and a blood pressure checking service. It also provides some private services including a pharmacist led prescribing service with face-to-face consultations, and ear wax removal. Some medicines are supplied to people in multi-compartment compliance packs to help them take their medicines correctly. And a medicine delivery service is available.

Overall inspection outcome

Standards not all met

Required Action: Improvement Action Plan

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 not all met	1.1	Standard not met	The pharmacy does not document the risks associated with its prescribing service. There is no evidence of the mitigating actions that have been taken to help deliver the service safely. It does not have a prescribing policy available to help make sure the service is provided safely and effectively.
		1.6	Standard not met	The pharmacy does not always keep a record of the consultations that it completes for the supply of repeat medication to people when using the prescribing service. It does not retain evidence of people's usual doctor being notified that the service has been accessed or a prescription issued.
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 not all met**

Summary findings

The pharmacy does not effectively identify and manage the risks associated with its pharmacist led prescribing service. It does not document the risks that are linked to the service to demonstrate how it effectively mitigates them. There are no prescribing policies in place to help make sure the service is provided safely. The pharmacy generally keeps records of people accessing the prescribing service. But in some cases, records aren't made for repeat supplies of medicines which may make it difficult to justify why the supply was made. The pharmacy notifies people's usual GP when they use the service but evidence of this is not maintained. So it may make it harder for the pharmacy to demonstrate that it provides adequate information required for continuity of care. Members of team make a record of their mistakes, and some reviews are completed to help team members identify any common mistakes or trends. They know how to protect private information and aware of the steps to take to protect vulnerable people.

Inspector's evidence

A pharmacist-led prescribing service was being provided by the superintendent pharmacist (SI) who had qualified as an independent prescriber in Ear, Nose and Throat (ENT) conditions. The service was not actively promoted and the number of people accessing the service was low. Consultations were carried out in the pharmacy and people were referred into the service by local GP practices. Prescriptions has been generated by the SI to help treat ENT issues but some prescriptions for erectile dysfunction had also been issued.

The SI explained they had assessed the risks associated with the service before providing it but there was no documentation to demonstrate this. There was no evidence of what mitigations had been considered to help reduce the risks around the service. There were no policies or written procedures available to help make sure the service was delivered safely and in a consistent manner. Records of the consultations were kept in both electronic and paper forms. They generally contained sufficient information to demonstrate that relevant clinical assessments had been completed by the prescriber to support their decision making before issuing a prescription. However, some prescriptions had been issued that did not have any consultation notes. The SI admitted that the consultation was not recorded if the person was returning for a repeat supply of the same medication. This may make it harder for the pharmacy to justify why the supply was made. The pharmacy notified the person's GP by email if a prescription had been issued but it did not keep a record of this. This meant there was no evidence of communications to help support the continuity of care.

The pharmacy had a mixture of paper and electronic procedures available which covered most of the other services that it provided. Some standard operating procedures (SOPs) had recently been updated following the installation of a new patient medication record (PMR). They were accessed electronically and a record to show which team members had read and accepted them was available. However, paper SOPs did not have any training records and so it was difficult to show team members had read them. The SI provided an assurance that all SOPs had been read. They were in the process of converting all the SOPs into an electronic format as it was easier to provide an audit trail. Three pharmacy technicians who were trained to complete accuracy checks (ACTs) were employed by the pharmacy. They checked prescriptions for accuracy that had been assembled by other members of the team. One ACT explained there was no restrictions on the types of medicines that they checked. An SOP was available explaining

the remit of the ACTs responsibilities to make sure that the process was completed safely, and so that a responsible pharmacist (RP) understood the process.

Other roles and responsibilities were stated in the procedures and team members explained what their role was. When questioned, a few members of the team were able to correctly explain what they can and cannot do if the RP took a short leave of absence although this rarely occurred as there were two pharmacists on duty most of the time. A complaints procedure was available, and it was advertised in the retail area so that people knew how to provide feedback. Evidence of current professional indemnity insurance was seen.

Mistakes that had been identified as a part of the final accuracy check, known as near misses, were recorded on an electronic platform. Only two records had been made since January 2024. The SI explained the number had dramatically reduced because of the PMR which had functionality to detect picking errors. The mistakes were dicussed with team members at the time they were identified to help them learn from them. Records of dispensing errors, which is when an error is identified after the medicine is supplied to the person, were seen. Details were available to show what had happened and the steps taken to try and reduce the risk of similar errors happening again. Errors were reviewed informally and this was shared with team members during team meetings to help them identify improvements.

The pharmacy largely kept the records it was required to by law. A private prescription register was maintained electronically and contained all the relevant details needed. Records of unlicensed medicines that had been supplied were available. Controlled drugs (CD) registers were stored electronically and were up to date. Running balances were kept. A few running balances were checked against the physical stock and found to be correct. Patient returned CDs were recorded appropriately. RP records were also held in an electronic format with sign in times recorded. However, the pharmacists were not routinely signing out to show when their responsibility had ended. This may make it harder for the pharmacy to respond to any questions following a mistake or concern being raised. This was highlighted to the SI, and they provided an assurance that an accurate record will be maintained going forwards.

Members of the team had signed confidentiality agreements which were part of their employment contract and training on information governance had been complete. This helped to keep their knowledge up to date. An SOP detailed how the pharmacy handled confidential information. When questioned, a team member explained that confidential waste was separated from general waste and shredded. Another team member explained they would offer the use of the consultation room if a person required a private conversation.

Procedures about safeguarding vulnerable people were available and the contact details of the local safeguarding leads were accessible. The SI and pharmacy technicians had completed formal training about safeguarding. Team members were able to explain they action they would take if any concerns were identified.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough staff to manage its workload effectively. Most pharmacy team members are appropriately trained for the jobs they do. But some team members are not enrolled on to a suitable training course in a timely manner. This may mean they do not have the correct skills or knowledge for their role. Team members feel comfortable speaking up about any concerns they have.

Inspector's evidence

The pharmacy team consisted of a regular RP who was also the SI, three ACTs, one trainee pharmacy technician on an apprenticeship programme, one qualified dispensing assistant, one trainee dispensing assistant and three medicines counter assistants (MCAs). One of the MCAs had not completed any formal training and had not been enrolled on to a suitable training course. There were also two team members who worked on Saturdays as support staff but neither had completed any training for their roles. This was discussed with the SI as there was a risk that they may not have the correct skills and knowledge or their role. Subsequent evidence was provided to show that all four team members had been enrolled on to a training course with a recognised provider. A foundation pharmacist who had recently completed their training year was also supporting the team. They had been trained to deliver some of the services on offer such as the blood pressure testing service and the initial ear examination for the micro suction service.

Locum pharmacists were also used to cover some of the opening hours. Absences were planned where possible and team members covered each other to help make sure the service level was not affected. Pharmacy team members were observed prioritising the workload and helping each other to manage tasks safely and effectively. The RP was seen making themselves available to support with any queries.

A dispenser was able to provide an explanation of the questioning technique used when selling medicines to makes sure sales were appropriate and gave appropriate examples of situations when they would refer to the pharmacist. They also identified higher-risk pharmacy medicines and explained they took extra care when selling these. Multiple requests for medicines liable to abuse were referred to the RP. Team members received an appraisal every quarter to discuss their performance. It was also an opportunity to provide feedback to the SI and discuss any development opportunities.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy's premises are professionally presented and are suitable for the services offered. Two consultation rooms are available for people to have a conversation with a team member in private or receive a service.

Inspector's evidence

The premises were bright, well presented, and secured when closed. The retail area was appropriately presented. The pharmacy had air conditioning and heating to ensure the room temperature was maintained at an appropriate level. A large dispensary area was situated at the back of the pharmacy and access was restricted by the front retail counter. There was adequate bench space and storage available for its current workload. The pharmacy team were responsible for keeping the premises clean and tidy. Clean sinks with a supply of hot and cold running water were available for the preparation of medicines.

The pharmacy had two consultation rooms which were an appropriate size for the services being offered and were easily accessible from the retail area. A small storage area and WC were available and accessed from the retail area. Access to these were appropriately restricted from unauthorised access.

A website (https://www.easonpharmacy.co.uk/) had been set up to help the pharmacy promote some of its services. Medicines could not be brought online. The website detailed the address and registration details of the pharmacy. It also displayed the registration details of the SI.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy obtains its medicines from licensed sources and stores them appropriately. It generally supplies medicines safely, and it highlights higher-risk medicines to team members to help them provide people with additional information about these medicines. And it takes the right action if medicines or devices are not safe to use. It delivers medicines to some people in their own homes effectively and safely. Members of team are adequately trained to provide the services that are on offer.

Inspector's evidence

Access to the pharmacy was step-free with an automatic door at the entrance which made it easy for someone using a wheelchair or a pram to enter the premises. The opening hours and services on offer were clearly advertised in the shop window.

A range of NHS and private pharmacy services were actively being provided. This included NHS Pharmacy First services, blood pressure testing and a private ear micro-suction service. The SI had complete relevant training to provide these services and had signed the relevant paperwork, such as patient group directions (PGD), to deliver them safely. A weight loss service was being provided using a PGD from a recognised provider. People using the service had to attend the pharmacy on a regular basis to have their weight monitored. The face-to-face prescribing clinic was mainly to treat ENT conditions. Most people were referred into the service by local GP surgeries but on some occasions, pharmacy team members also made the referral if they felt it would benefit the person. Only a few prescriptions for antibiotics for ear infections had been issued. On occasion, the SI had prescribed treatments for erectile dysfunction.

The pharmacy received NHS prescriptions electronically and they were clinically checked by the pharmacist before being processed for assembly. The pharmacy computer system also carried out some clinical checks based on the patient's medicine history. If there were no changes to the previous month, then a clinical check would automatically be completed. Any medicines changes, including changes to the dosage or form, required a pharmacist to confirm that the prescription was clinically safe. Once the clinical check was complete, the prescription was processed by a dispenser. They scanned a 2D barcode on the medicine packaging to generate a dispensing label. This helped to make sure that the correct medicine had been dispensed. If all was correct, a label was generated and attached to the medicine box. If there was a mismatch between the dispensed medicine and the prescription, a warning box would appear on the computer to prompt the team member to double check the medicine. Medicines that required an accuracy check by the ACT or pharmacist were placed into a basket. The pharmacy computer system also completed some of the accuracy checks if the prescriptions and medicines were all scanned in properly. Any prescriptions that were manually changed by a member of the team, for example a change in dosage instructions from the details on the prescription, required an accuracy check by a pharmacist or ACT. Baskets were used to separate people's prescriptions and different coloured trays were used to help prioritise the workload. Each dispensing label had a 2D barcode printed on it and when scanned it showed who was involved in the dispensing and checking process. This means that the pharmacy could easily identify which members of the team were involved in the assembly of a prescription of a dispensing mistake was to occur.

Prescriptions for Schedule 3 and 4 CDs were highlighted to help the pharmacy team members make sure they were not handed out beyond the prescription's legal validity. And team members also highlighted prescriptions which required a fridge item to be added before being supplied to people. The pharmacy team explained that they use a variety of stickers to highlight any medicines that may require the pharmacist to counsel the patient or ask additional questions. The PMR system also identified people taking higher-risk medicines and team members asked appropriate questions to make sure blood tests and monitoring were up to date. The pharmacist was aware of the additional counselling about pregnancy prevention required with sodium valproate products and the steps to take for people in the at risk-group. This also included providing valproate containing medicines in their original container so that the patient warning card and patient information leaflet were provided with each supply. A medicine delivery service was provided to those who preferred to have the medicines sent to their home. The delivery service was completed by a delivery driver and an audit trail of successful deliveries was kept.

Some people in the local area were supplied their medicines in multi-compartment compliance packs to support them with managing their medicines. Records were maintained to help make sure the packs were dispensed accurately each month and provided in a timely manner. A few packs were checked but the labelling did not include descriptions of the medicines that had been dispensed, so people may find it difficult to identify them. And the backing sheets were not attached securely so there was a risk of them being misplaced. This meant any information about who the pack belongs to, and the medicines would not be available. The risk of this was discussed with the team member in charge of the service who agreed that some improvements were required. Patient information leaflets were being supplied with the packs, making it easier for people to access additional information if needed. Communication sheets were available for each patient that received the packs which the pharmacy team members used to record any changes initiated by the doctor or hospital. Any hospital discharge paperwork was retained.

The pharmacy used a range of licensed wholesalers and medicines were stored appropriately in the original packs. Access to prescription medicines was restricted. The expiry dates of medicines were checked every three months by members of the team and a record of this was maintained. A selection of medicines stored on the shelves were checked, and none were found to be out of date. And liquid medicines had a date of opening written on them. The pharmacy had a several suitable fridges available, which was within the appropriate temperature range for medicines that required cold storage. A daily record of the fridge temperatures was stored electronically. The pharmacy had a secure CD cabinet available to use. CDs that had been returned to the pharmacy were clearly marked and separated from stock CDs. The pharmacy received alerts regarding defect medicines by email. Its team members checked the pharmacy for any affected stock and made a record of the actions taken.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has all the equipment it needs to provide services safely. It has appropriate systems in place to protect people’s confidentiality.

Inspector's evidence

The pharmacy team had access to relevant equipment needed for the services it provided which was kept clean. Team members had access to up-to-date reference sources. And it contacted the National Pharmacy Association to ask for information and guidance. The pharmacy had access to equipment such as an otoscope and blood pressure monitor to provide NHS Pharmacy First services. A digital otoscope and micro suction machine for ear wax removal was also available both of which were maintained by an external company. Three medical refrigerators were available to store medicines which required refrigeration. A data logger was used to record and log the minimum and maximum temperatures.

Computer screens were positioned in away so that they could only be seen by members of the pharmacy team. All team members had individual log in credentials to access the computer system. The pharmacy had a cordless phone so team members could move to a more appropriate area for private conversations.

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.