General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: High Street Pharmacy, 76 High street, Bilston, West Midlands, WV14 0EZ

Pharmacy reference: 1037872

Type of pharmacy: Community

Date of inspection: 14/08/2019

Pharmacy context

The pharmacy is located next to a supermarket, in the centre of a busy market town. There are several other pharmacies in the surrounding area and a GP surgery is also close-by. The pharmacy dispenses NHS prescriptions. It provides medicines in multi-compartment compliance aid packs to help make sure people take them at the correct time and it delivers medicines to people who are housebound. The pharmacy offers several other NHS services including a local minor ailments 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	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 has some risk management processes. It keeps people's private information safe and maintains the records it needs to by law. But some records lack detail, so the pharmacy might not always have access to all the information it needs in the event of a query. Pharmacy team members understand their role in protecting vulnerable people. They sometimes record their mistakes, so that they can learn from them. But records contain limited information, so they may miss some learning points and opportunities for improvement.

Inspector's evidence

The pharmacy had a set of standard operating procedures (SOPs) which had originally been issued by the previous owner in 2016 and 2017. The pharmacist had stamped a recent record sheet to indicate that he had reviewed them in 2019 and considered them still suitable for use. This had been signed by staff to confirm their acknowledgment and understanding. But there were instances where the procedures were not being followed, so tasks were not always completed as effectively as they could be. A medicine counter assistant (MCA) discussed her role and was clear on her responsibilities, which were defined in the SOPs. This included demonstrating an understanding of the activities which were permissible in the absence of a responsible pharmacist (RP). The pharmacist, who was also a director and the superintendent pharmacist, provided evidence of professional indemnity insurance cover sourced through Pharmacy Guard.

The pharmacy kept basic records of near misses, which recorded the name of the staff member involved and a running total of the type of near miss, such as incorrect strength. The log did not record any additional information such as medications involved or the date and time the near miss took place, and entries were limited. The pharmacist said that he would review the log periodically, but no record of this was kept and no changes had been made in response to previous near misses. The pharmacist showed the inspector how he would record the details of any dispensing incidents through the patient medication record (PMR) system and stated that no incidents had been identified since he had acquired the pharmacy around two years ago.

The details of any concerns were referred to the pharmacist. The pharmacy did not advertise its complaint procedure, so people might not always be aware of how concerns can be raised. Feedback was sought through an annual Community Pharmacy Patient Questionnaire (CPPQ) and previous results appeared generally positive. The MCA also said that people were able to leave additional reviews and feedback online.

The correct responsible pharmacist (RP) notice was displayed near to the medicine counter. The electronic RP log appeared compliant as did specials procurement records which provided an audit trail from source to supply. Records of emergency supplies appeared in order, but there were some delays to the recording of private prescriptions. A few prescriptions from June and July had not been entered. This was discussed with the pharmacist, who was aware of the timeline for entries to be made and

agreed to record the prescriptions as a priority. Controlled drugs (CD) registers kept a running balance and a patient returns CD register was in use.

The pharmacy had several information governance procedures. These had not been signed by team members to confirm acknowledgement, but the pharmacist said that procedures around confidentiality and information management had been discussed informally. The pharmacy was registered with the Information Commissioner's Office and a privacy notice was available in the information governance folder. The MCA demonstrated an understanding of how she would protect privacy in the pharmacy. Confidential waste was segregated and removed for appropriate disposal and the appropriate use of NHS smartcards was seen on the day. The pharmacist kept records of consent for access of Summary Care Records (SCR) as an audit trail.

The pharmacist had completed some safeguarding training. He discussed a previous incident where a concern had been raised to help protect a vulnerable person. And the contact details of local safeguarding agencies were available to support escalation.

Principle 2 - Staffing ✔ Standards met

Summary findings

Pharmacy team members understand their roles and generally manage the workload suitably. But recent staff shortages have created some additional pressure, which could impact on the ability to complete some non-urgent tasks effectively. Team members hold the appropriate qualifications for their roles or are enrolled on training courses. They complete some ongoing training, but this is not structured, and they do not always get regular feedback on their performance. So, some opportunities for learning and improvement may be missed.

Inspector's evidence

On the day of the inspection the regular pharmacist was working alongside a trained MCA. A delivery driver was also present for a short period of time. The pharmacy employed a full-time dispenser who was enrolled on a pharmacy technician apprenticeship through a local college and a part-time dispenser, who was a pharmacy student. Neither were present on the day due to commitments with their training providers, so the pharmacy was under staffed and this meant that the pharmacist was self-checking prescriptions, taking a mental break between each activity to help to reduce the likelihood of mistakes. The pharmacist reported that this situation was unusual as the full-time dispenser was usually always present, except on college days. He used a locum agency to arrange dispensary cover, when required but the company had been unable to source cover for that day. Staffing levels were due to return to the usual level the day after the inspection. The pharmacy was also actively recruiting for two vacancies, with one accuracy checking pharmacy technician (ACT) due to begin employment in the coming weeks. An additional apprentice position was also being considered. The vacancies were to fill the positions of two other team members who had recently left. During the interim period the workload had been more challenging, but the team had remained up to date with the dispensing activities. The pharmacist usually used an online human resources platform to manage requests for leave and help maintain sufficient staffing levels.

The pharmacist and MCA discussed some concerns that had previously been identified when selling over-the-counter medicines, and sales had been refused where appropriate. The MCA referred concerns to the pharmacist and asked appropriate questions to help make sure that sales were safe and appropriate. The MCA demonstrated an understanding of some high-risk medicines and provided an appropriate response to a question regarding the sale of a pseudoephedrine-based medicine. She had completed an appropriate training programme provided by Buttercups and her certificate was displayed in the retail area. There was limited ongoing training in the pharmacy. The pharmacist had recently signed up to a new support agency, who were providing some materials to support ongoing learning and development and a plan was being put into place to provide team members with time to utilise the materials. But this was not active at the time of the inspection. The apprentice dispenser attended college once a week. His development was being monitored by a college tutor, who carried out observations every two months and liaised with the pharmacist. The pharmacist had not carried out any other recent staff reviews to identify learning needs.

There was an open dialogue between the pharmacist and MCA and the MCA was comfortable to approach the pharmacist with any concerns. The pharmacist did not set any formal targets for

professional services.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy provides a secure and clean environment suitable 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.

Inspector's evidence

The pharmacy's premises including the external facia was in an appropriate state of repair. Maintenance issues were escalated to the landlord by the pharmacist, so that necessary repairs could be arranged. And pharmacy team members carried out daily cleaning duties. Overall, the pharmacy was generally clean and tidy on the day. There was adequate lighting throughout and the temperature was appropriate for the storage of medicines. A portable air conditioning unit was available to support temperature regulation during periods of warm weather.

The retail area was spacious, the walkways were kept clear of obstructions and chairs were available for use by people who were less able to stand. The pharmacy stocked a range of goods which were suitable for a healthcare-based business and a several health promotion displays could be found in various locations. One pharmacy restricted teething medicine was identified on the retail shelves, this was immediately removed and placed behind the counter and the team were advised to review recent guidance relating to the change of legal status of several lidocaine based teething preparations. All other pharmacy restricted medicines were secured from self-selection behind the medicine counter.

The pharmacy had a signposted consultation room to help provide members of the public with an area for confidential discussions. The room was compact which may limit accessibility for some individuals, but it was appropriately maintained and tidy.

The dispensary had three large workbenches which provided an organised workflow and enabled the segregation of dispensing and checking. Several large shelving units provided adequate storage space for medicines and other paperwork and helped to keep work benches clear of unnecessary clutter. A separate sink was available for the preparation of medicines and was equipped with appropriate hand sanitisers and other cleaning materials. Other storage areas and staff facilities were also suitably maintained.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's services are generally accessible to people with different needs and they are suitably managed to help make sure that people receive appropriate care. The pharmacy sources medicines from reputable wholesalers and it carries out some checks to make sure that they are suitable for supply. Pharmacy team members identify people on high-risk medicines to help make sure that they receive appropriate monitoring.

Inspector's evidence

There was limited advertisement of the pharmacy's services, so people may not always know what is available. A practice leaflet was not available for selection but the pharmacist said that he would obtained further copies. The team were observed to signpost some patients to other healthcare providers and information was available to support this. The pharmacy's services were accessible from the main High Street through a step-free entrance and an automatic door aided access for wheelchair users. Additional adjustments were available to assist people with different needs, including a hearing loop device. And team members were dual lingual, often conversing with people in other languages including Punjabi, to help provide counselling and effectively resolve queries.

Prescriptions were segregated using baskets to keep them separate and reduce the risk of medicines being mixed up. The pharmacy used 'dispensed' and 'checked' boxes on dispensing labels as an audit trail to identify those involved. The pharmacy segregated prescriptions where medications were owed. These were reviewed daily to identify any manufacturing issues and the pharmacist said that he liaised with the local practice pharmacist to obtain alternatives, or offered patients the opportunity to take their prescription elsewhere. It did not routinely highlight all prescriptions for CDs, and the team accepted that this may increase the risk that a supply could be made beyond the valid 28-day expiry date. The pharmacist provided appropriate responses to questions regarding the supply of valproate-based medicines to people who may become pregnant. Some branded packs of valproate-based medicines had alert cards attached to the packaging so that the pharmacy could provide them at the time of supply. But the pharmacy did not have access to other safety literature in line with recent guidance issued by the Medicines and Healthcare products Regulatory Agency (MHRA). The inspector advised on how these could be obtained. The pharmacist said that people on other high-risk medicines would asked questions about their monitoring at the time of the supply, but records of this were not routinely maintained as an audit trail.

The pharmacy provided a repeat prescription collection service to several local surgeries. They used a diary to keep a basic audit trail of repeat requests sent to the GP surgery and proactively highlighted unreturned prescriptions so that they could be followed up. The diary was also used to track repeat requests which were placed for people who used multi-compartment compliance aid packs. Requests were managed using a four-week cycle and each patient had a master record of medicines, which was updated to reflect any changes which were made. Completed packs were labelled with patient identifying information to the front, and the backing sheet provided descriptions of individual medicines, but did not state the details of any warning labels relating to precautions of using medication. So, people may not have access to all of the information they need to take their medicines

properly. The pharmacist said that he would contact the PMR provider to discuss this.

The pharmacy used a delivery application to track deliveries and help make sure that medications were supplied safely and securely. The details of each day's deliveries were recorded onto the system, with additional features in place for fridge medications and CDs. The driver obtained signatures to confirm delivery and failed deliveries were returned to the pharmacy. The phone used by the drivers was password protected and was secured out of hours.

Stock medications were sourced through reputable wholesalers and specials from a licensed manufacturer. There were a small number of medicines which were being stored in brown medicine bottles. They were not labelled with the batch number and expiry, and were removed by the pharmacist once identified. The pharmacy carried out some date checks, but checks were not always at the frequency stated in SOPs. Short-dated medicines were highlighted and no out of date medicines were identified from random checks. Returned and expired medicines were placed into medicine waste bins. A cytotoxic waste bin was not available for the segregation of hazardous materials. The pharmacy was not yet compliant with the requirements of the European Falsified Medicines Directive (FMD). The pharmacist had obtained a scanner but said that he had encountered problems relating to the necessary software, which was currently in the process of being resolved. The pharmacy received and actioned alerts for the recall of faulty medicines and medical devices and kept an audit trail to demonstrate the action that had been taken in response.

CDs were stored in an organised manner with out of date and returned CDs clearly segregated from stock. Random balance checks were found to be correct and CD denaturing kits were available. The pharmacy fridge was fitted with a maximum and minimum thermometer and the temperature was checked and recorded daily. The fridge was within the recommended temperature range on the day.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

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

Inspector's evidence

The pharmacy had access to paper pharmaceutical reference sources including the British National Formulary and a Drug Tariff. Internet access supported additional research. The pharmacy's equipment was appropriately maintained. The glass measures were crown-stamped and separate measures were marked for use with CDs. Counting triangles were clean and a separate one was available for use with cytotoxic medicines.

Electrical equipment was in working order. Computer systems were password protected to help prevent unauthorised access and all screens were located out of public view. Pharmacy team members had access to a cordless phone 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.