General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Beacon Pharmacy, 79-81 Collingwood Drive, Great Barr, BIRMINGHAM, West Midlands, B43 7JW

Pharmacy reference: 1037942

Type of pharmacy: Community

Date of inspection: 23/09/2024

Pharmacy context

This pharmacy is located on a parade of shops in the Great Barr area of Birmingham. It mainly dispenses prescriptions and supplies some people with medicines in multi-compartment compliance packs to help them manage their medicines. The pharmacy also provides other services such as the NHS Pharmacy First, the NHS Hypertension Case-finding service, seasonal flu vaccinations, and other private services such as travel vaccinations, vitamin B12 injections, weight management, period delay and ear wax removal.

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's working practices are safe and effective. It keeps the records it needs to by law, and it has procedures in place to help the team learn from mistakes. The pharmacy team knows how to help protect the welfare of vulnerable people.

Inspector's evidence

Standard operating procedures (SOPs) were available and team members had read and signed the SOPs relevant to their roles. Most SOPs had been reviewed in 2023 but there was one SOP that had no recorded date of review since 2010. Following the inspection, the superintendent pharmacist (SI) confirmed that all SOPs had been reviewed the previous year, and he was in the process of reviewing them again.

The team tried to separate labelling and assembly of prescriptions by using different team members to complete these tasks. Dispensing mistakes which were identified before the medicine was supplied to people (near misses) were recorded on a log. Team members recorded their own errors. Any labelling errors were also recorded. Near misses were discussed with the team member who had made the error. Reviews of errors were completed on a monthly basis by one of the pharmacists, and findings were discussed with the team. Following past reviews, stickers had been attached to shelves where medicines which 'looked-alike' and 'sounded-alike' were kept. For example, pregabalin was stored separately. Team members had been asked to highlight the preparation when a trend in errors between ramipril capsules and tablets had been identified. Any instances where a dispensing mistake had happened, and the medicine had been supplied to the person (dispensing errors), an investigation was completed. The error was also discussed with the team and an electronic record was made. In addition to this, a flashing note was made on the person's electronic record which prompted team members to double check when dispensing future prescriptions. Team members had all been briefed on double and triple checking their own work before passing on for a final check.

The pharmacy had current professional indemnity insurance. A complaints procedure was available. Complaints were discussed with the team and escalated to the SI if needed. Following feedback from people using the pharmacy, the ear wax removal service had been launched.

The correct responsible pharmacist (RP) notice was displayed. When questioned, team members were aware of the activities that could not be carried out in the absence of the RP. Private prescription, RP records, controlled drug (CD) registers and records of unlicensed medicines supplied were well maintained. Running balances were recorded. A random balance was checked and found to be correct. The pharmacy did not routinely give out emergency supplies and people were referred to the NHS 111 service. CDs that were returned to the pharmacy were recorded in a register and destroyed.

Assembled prescriptions that were ready to collect were stored in the dispensary The pharmacy had an information governance policy available, and its team members had read through the documents. The pharmacy separated confidential waste which was then shredded. Pharmacists had access to National Care Records (NCR) and obtained verbal consent from people before accessing it.

All team members including the delivery drivers had been briefed about safeguarding. Team members

had completed safeguarding training online. The SI provided assurance that he would ensure delivery drivers completed this too. If the team had concerns, they referred to the RP who was aware of the next steps to follow. Signposting information was displayed in the dispensary.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough team members to manage its workload safely. Team members work effectively together and support each other. They are able to discuss pharmacy related issues as they arise, and the pharmacy supports them to complete training courses.

Inspector's evidence

The pharmacy team comprised of the RP, who was a locum pharmacist, a pharmacy technician, a trainee technician, a trained dispenser, a trainee dispenser, a trained medicines counter assistant (MCA) and a new member of staff who had started working a few weeks before the inspection. Team members explained that there were usually two pharmacists working but both regular pharmacists were on leave. Team members explained that there were enough team members to manage the workload. Holidays and absences were covered within the team. The team was seen to be up to date with the workload, and despite an issue with flooding the previous weekend, the team was organised and calm.

Team members asked appropriate questions and counselled people before recommending over-the-counter medicines. They were aware of higher risk medicines and the maximum quantities that could be sold over the counter. Staff performance was managed by the SI. Team members had annual performance reviews with the SI and had one-to-one meetings in between. They were also provided with ongoing verbal feedback. Team members felt able to give feedback and suggestions and said that the regular pharmacists took any feedback on board and made changes accordingly.

Team members completing formal training courses described feeling well supported and were provided with allocated study time to complete their training coursework. They felt able to approach the pharmacists or colleagues if they needed help. To keep up to date team members completed online training modules and were briefed by both of the regular pharmacists on any changes or new services. They also attended training sessions held by the Local Pharmaceutical Committee (LPC). The team held meetings every fortnight and also discussed matters as they arose. Targets were set for the services provided and team members were encouraged to inform people about the services available. But there was no pressure to meet the targets.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy's premises are clean, secure and provide an appropriate environment to deliver its services safely. People can have a discrete conversation with a team member in a private consultation room.

Inspector's evidence

The premises were clean and organised. The dispensary had ample working space and specific areas were allocated for completing certain tasks. The retail area was large, tidy and clear of clutter. A sink was available for the preparation of medicines. Cleaning was done by members of the team. The room temperature and lighting were appropriate.

The premises had been flooded over the weekend, the affected area had been cordoned off and people were either being escorted to the consultation room or a quiet area in the shop was being used for private conversations. Contractors had been in to solve the issue and repair the damage caused. The premises were kept secure from unauthorised access. A clean, signposted consultation room was available and suitable for private conversations.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides its services safely. It obtains its medicines from licensed sources and manages them appropriately so that they are safe for people to use. It takes the right action in response to safety alerts so that people get medicines and medical devices that are safe to use.

Inspector's evidence

The pharmacy was accessible from the street. The shop floor was clear of any trip hazards and the retail area was accessed easily. Team members assisted people who needed help entering the pharmacy, or they attended to people at the door if they called the pharmacy when they were outside and unable to access the pharmacy. The pharmacy team were familiar with other services provided locally and had a list of services displayed for reference. They also used the internet to signpost people who needed services that the pharmacy did not provide. Some team members were multilingual, and the team also used electronic translation applications.

Team members felt the NHS Hypertension Case-finding service had the most positive impact on the local population as it was accessible to most people. There had been a number of cases where people had been referred back to their GP and prescribed antihypertensives. The GP practice across the road from the pharmacy had made a number of Pharmacy First referrals. The locum pharmacist working on the day of the inspection had completed face to face training for this service which included using an otoscope and they had also read through the policies.

There was an established workflow within the dispensary and prescriptions were labelled by one of the dispensers and then assembled by the other dispensers and checked by the RP. 'Dispensed-by' and 'checked-by' boxes were available on dispensing labels, and these were routinely signed to create an audit trail showing who had carried out each of these tasks. The dispenser who had generated the labels usually initialled the prescription. Baskets were used to separate prescriptions, to prevent them being mixed up. Prescriptions for paediatrics and CDs were highlighted for the pharmacist to double check.

The pharmacy team were aware of the risks associated with the use of valproate containing medicines. One person received a valproate containing medicine not it its original pack as this was more appropriate for their needs. A written risk assessment had not been completed, but team members provided an assurance that they would inform the SI that one needed to be completed. Team members were also aware of the guidance for dispensing topiramate. Additional checks were carried out when people were supplied with medicines which required ongoing monitoring.

Some people's medicines were supplied in multi-compartment compliance packs. Three team members were trained to manage the service. Packs were prepared by the dispensers. Prescriptions were ordered by the pharmacy a week in advance. They were checked against the electronic record for any changes or missing items. Usually, the surgery or the patient or carer notified the team of any changes in advance. Assembled packs were labelled with product descriptions and the mandatory warnings. There was an audit trail to show who had prepared and checked the packs. Patient information leaflets were routinely handed out.

The pharmacy offered a prescription delivery service and it had two designated delivery drivers. The drivers had a delivery log sheet and signatures were obtained from people when CDs were delivered. If someone was not available to receive a delivery, the medicines were returned to the pharmacy.

Medicines were obtained from licensed wholesalers and stored appropriately. Fridge temperatures were monitored daily and recorded; they were seen to be within the required range for storing temperature-sensitive medicines. Team members explained that date checking was done three monthly and a date checking matrix was available to demonstrate this. A random sample of stock was checked, and no date-expired medicines were found. Out-of-date and other waste medicines were separated and then collected by licensed waste collectors. Drug recalls were received electronically. The team would check the stock and take the action as required; alerts were printed and signed once they had been actioned and then filed.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

Members of the pharmacy team have access to the equipment and facilities they need for the services they provide. The pharmacy uses its equipment to help protect people’s personal information.

Inspector's evidence

The pharmacy had calibrated glass measures and tablet counting equipment was available. Separate measures were used for liquid CDs and separate triangles for cytotoxic medicines to avoid cross contamination. An electronic tablet counter was available which team members said was deep cleaned once a week and wiped down after each use. A large fridge was available. Three blood pressure monitors, an ambulatory blood pressure monitor, otoscope and thermometer were available and used as part of the services provided. The team were unsure of the calibration arrangements but provided an assurance that they would speak to the SI. Up-to-date reference sources were available including access to the internet. The pharmacy's computers were password protected and screens were not visible to people using the pharmacy.

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.