General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Your Local Pharmacy, 238 Wheelwright Road, Erdington, BIRMINGHAM, West Midlands, B24 8EH

Pharmacy reference: 1038170

Type of pharmacy: Community

Date of inspection: 06/02/2023

Pharmacy context

This is a traditional community pharmacy located in a residential area of Erdington, West Midlands. People who use the pharmacy are from the local community and a home delivery service is available. The pharmacy primarily dispenses NHS prescriptions, and it provides some other NHS funded services. The pharmacy team dispenses medicines into multi-compartment compliance packs for people to help make sure they remember to take them. Private services are also available, and these include travel vaccinations, and earwax removal. Enforcement action has been taken against this pharmacy, which remains in force at the time of this inspection, and there are restrictions on the provision of some services. The enforcement action taken allows the pharmacy to continue providing other services, which are not affected by the restrictions imposed.

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 manages the risks associated with its services to make sure people receive appropriate care. Members of the pharmacy team follow written procedures to make sure they work safely. They record their mistakes so that they can learn from them, and they make changes to stop the same sort of mistakes from happening again. The pharmacy team keeps people's information safe and team members understand their role in supporting vulnerable people.

Inspector's evidence

A range of standard operating procedures (SOPs) were in place which covered the operational activities of the pharmacy and the services provided. SOPs were reviewed and updated on an ongoing basis. The pharmacists had developed the SOPs to reflect the pharmacy services provided. The latest versions of the SOPs were held electronically. Pharmacy team members accessed their personal SOP record which confirmed that they had read them. The Responsible Pharmacist (RP) had access to a reporting function and demonstrated that each member of the team had read SOPs that were relevant to their job role. Roles and responsibilities were highlighted within the SOPs.

Many of the pharmacy's processes and records were managed electronically, which meant that records were easily accessible, and the computer system included automatic alerts to remind the pharmacy team to do certain tasks. Near miss records were held on this system and a 'dashboard' summarised the number of near misses recorded. There were Quick Response (QR) codes displayed in the dispensary so that the dispensers could scan the QR code using their mobile phone and enter the details of the near miss. The pharmacy team gave some examples of different types of mistakes and demonstrated some examples of how processes had been adapted to try and avoid the same mistake happening again. The near miss log was reviewed by the pharmacists at the end of the month and the learnings were recorded. The outcome of the review was recorded electronically and used to create an annual patient safety review for the NHS Pharmacy Quality Scheme (PQS) report. Dispensing errors were recorded and reviewed on the electronic system: examples of dispensing errors were seen. The action taken to prevent reoccurrence section was minimal, which meant that some learning opportunities may have been overlooked.

Each member of the team had an individual log-in for the patient medication record (PMR) system which provided an audit trail. The barcode on the product was scanned during dispensing and the system only printed off a dispensing label if the medication scanned was correct. A clear warning message was displayed on the screen if it was incorrect. NHS prescriptions were downloaded from the NHS spine and this information was used for dispensing which reduced the risk of a member of the pharmacy team entering incorrect information into the computer system during the dispensing process. The pharmacists regularly accessed management information that showed the percentage of products scanned and the number of incorrect barcodes scanned. These checks showed whether the pharmacy team members were complying with the process and their dispensing accuracy. There were additional processes for split packs, packs without barcodes and certain medicines that the team had identified as high-risk.

Members of the pharmacy team were knowledgeable about their roles and discussed these during the inspection. A medicines counter assistant correctly answered hypothetical questions related to high-risk medicine sales.

The pharmacy's complaints process was explained in the SOPs. People could give feedback to the pharmacy team in several different ways; verbal, written and via email. The pharmacy team tried to resolve issues that were within their control and would involve one of the senior members of the pharmacy team if they could not reach a solution.

The pharmacy had up-to-date professional indemnity insurance. The Responsible Pharmacist (RP) notice was clearly displayed, and the RP log met requirements. Controlled drug (CD) registers were in order and two random balance checks matched the balances recorded in the register. Private prescription records were seen to comply with requirements. Audit trails for home deliveries were maintained using a smartphone app.

Confidential waste was stored separately from general waste and destroyed securely by a specialist company. The pharmacy team had their own NHS Smartcards and confirmed that passcodes were not shared. The pharmacists had completed level two training on safeguarding. The pharmacy team understood what safeguarding meant. A dispensing assistant gave examples of types of concerns that she had come across, and what action that she had taken as a result. Intervention records and other messages were recorded on the PMR.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough team members to manage the workload and the services that it provides. The team members plan absences in advance, so the pharmacy has enough cover to provide the services. They work well together, and they know who to speak to if they need to raise concerns or make suggestions.

Inspector's evidence

The pharmacy support team comprised of the pharmacy manager (dispensing assistant), two dispensing assistants, an apprentice, a trainee medicines counter assistant, and two home delivery drivers. There were three regular pharmacists that covered the opening hours between them; one was the superintendent; one was the company director, and one was a regular locum pharmacist. The pharmacy was a family-run business. Several members of the pharmacy team worked additional hours and carried out extra duties to ensure the pharmacy ran smoothly. The RP reported that he was comfortable with the current staffing levels and that the operational processes had recently been changed so that they were more efficient.

Holidays were co-ordinated by one of the dispensing assistants and she checked that no-one else had already booked the same week before approving the request. Cover was provided by other staff members as required. Pharmacy team members completed ongoing training and training needs were identified to align with new services, seasonal events and the NHS Pharmacy Quality Scheme (PQS). The team had annual appraisals, and the apprentice had additional reviews carried out by her course tutor.

The pharmacy team worked well together during the inspection and were observed helping each other and moving from their main duties to help with more urgent tasks when required. Tasks were delegated to different members of the team so that the workload was managed, and this allowed the pharmacist to carry out services without creating a backlog of work. The pharmacy staff said that they could raise any concerns or suggestions with any of the pharmacists or company directors and felt that they were responsive to feedback. Team members said that they would speak to other members of the team, or GPhC if they ever felt unable to raise an issue internally. RP was observed making himself available throughout the inspection to discuss queries with people and giving advice when he handed out prescriptions, or with people on the telephone. Targets for professional services were not set.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy provides a safe, secure and suitable environment for people to receive healthcare services. The pharmacy team has access to a consultation room for services such as vaccinations, and if people want to have a conversation in private.

Inspector's evidence

The pharmacy was smart in appearance and appeared to be well maintained. Any maintenance issues were reported to the senior managers who had a list of local contractors. Dispensing activity took place over two floors and the majority was carried out on the upper floor, with the RP being based on the ground floor to supervise medicine sales and prescriptions being handed out. This workflow was a new process and the team reported that it worked well as the ground floor dispensary was compact and lacked workbench and shelf space. This had created clear workbenches downstairs and more storage space for completed prescriptions. The first floor comprised of two dispensaries, a stock room, and staff facilities. All areas were clean, tidy and well organised.

There was a private soundproof consultation room which was used by the pharmacist during the inspection. The consultation room was professional in appearance. The door to the consultation room remained locked when not in use. The pharmacy offered a COVID-19 vaccination service but this service was due to end a few days after the inspection. There was ample seating for people visiting for the vaccination service with Perspex partitions between each seat in the waiting area.

The pharmacy had heaters and portable fans. Lighting was adequate for the services provided. The dispensary was clean and tidy with no slip or trip hazards. The sinks in the dispensary and staff areas had hot and cold running water, hand towels and hand soap available. Cleaning was carried out by the pharmacy team. Prepared medicines were held securely within the pharmacy premises and pharmacy medicines were stored behind the medicines counter.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy offers a range of healthcare services which are easy for people to access. It manages its services and supplies medicines safely. The pharmacy obtains its medicines from licensed suppliers, and stores them securely and at the correct temperature, so they are safe to use. People receive advice about their medicines when collecting their prescriptions. The team supplies medicines in multicompartment compliance packs for those who may have difficulty managing their medicines.

Inspector's evidence

The pharmacy had step free access from the pavement and a home delivery service was offered to people who could not access the pharmacy. The pharmacy staff referred people to local services when necessary. They used local knowledge and the internet to support signposting. Pharmacy staff could speak to patients in English, Urdu, Punjabi Gujrati, and Swahili. Google Translate was also used.

The dispensing process had been designed using the in-built safety measures that the PMR system provided. The PMR system had been selected for these additional checks and because it helped the team to manage the workflow. Every prescription was clinically checked by a pharmacist before it was released for dispensing. The SOPs had been created to reflect the process that the team followed. The dispenser used a 'picking note' to gather the medication required in a basket, scanned the barcode on the picking note and then scanned the barcodes on each of the medicine boxes. The PRM system printed off medication labels if the item that had been scanned was correct, and a warning message was displayed if an item was incorrect. There were additional steps if the medicine was being supplied was not a full pack, it did not have a barcode, or was on a list of medicines that the team had identified as being 'high-risk' and required an additional check by the pharmacist before it could be bagged. Prescription items were dispensed into baskets to ensure prescriptions were not mixed up together. There was a quick reader (QR) code on the dispensing label and the computer system recorded which member of the team had been involved in each stage, so there was a dispensing audit trail for prescriptions. Repeat NHS prescription requests were made by the pharmacy team and there was an effective process in place for managing the process. The team were aware of the risks associated with the use of valproate during pregnancy, and the need for additional counselling. Patient cards and counselling materials were available.

Substance misuse prescriptions were dispensed the day before the patient was due to collect them and stored securely in the controlled drug (CD) cabinet. The RP demonstrated how the methadone dispensing machine worked including setting up the machine before use, calibrating the machine, dispensing, marking the dose as collected to populate the CD register, and closing down the machine after the last use. There was a contingency plan in place in the event of machine failure and the team could resort to manual dispensing if this happened.

The RP was an independent prescriber and had issued prescriptions for, and administered travel vaccinations, these were for patients that had attended the pharmacy for a face-to-face consultation and the service was not available online. The travel vaccination service and the ear wax removal service

were not heavily promoted as the pharmacy team were focusing on the provision of NHS services.

Multi-compartment compliance packs were used to supply medicines for some patients. People were telephoned before their next prescription was due to be ordered to ask which external items they required and if there had been any changes that the pharmacy team were not aware of. Prescriptions were ordered in advance to allow for any missing items to be queried with the surgery ahead of the intended date of supply. Each person had a record that showed what medication they were taking and when it should be packed. This record was used to record additional details about which dispensing assistant had been involved in each stage of the dispensing process. Notes about prescription changes and queries were kept on the patient medication record. A sample of dispensed compliance packs were seen to have been labelled with descriptions of medication and patient information leaflets (PILs) were sent with each supply. The dispensing assistant used a common-sense approach when talking to people about changes to compliance packs and did what was best for the patient.

Date checking took place regularly and no out of date medication was found during the inspection. There were date checking records maintained and short dated medicines were clearly marked as a visual reminder. Medicines were stored in an organised manner on the dispensary shelves. All medicines were observed being stored in their original packaging. Split liquid medicines with limited stability once they were opened were marked with a date of opening. Patient returned medicines were stored separately from stock medicines in a designated area. Medicines were obtained from a range of licenced wholesalers. Drug recalls were received electronically and marked when they were actioned.

The CD cabinets were secure and a suitable size for the amount of stock held. Medicines were stored in an organised manner inside. Fridge temperature records were maintained, and records showed that the pharmacy fridges were working within the required temperature range of 2°C and 8°Celsius.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide its services safely. And the team uses it in a way that keeps people's information safe.

Inspector's evidence

The pharmacy had access to a range of up-to-date reference sources, including the BNF and the children's BNF. Internet access was available. Patient records were stored electronically and there were enough terminals for the workload currently undertaken. A range of clean, crown stamped measures were available. Separate measures were used for methadone. The methadone dispensing machine was calibrated and cleaned daily and it was serviced regularly by the manufacturer. Counting triangles were available. Computer screens were not visible to the public as members of the public were excluded from the dispensary. Cordless telephones were in use and staff were observed taking phone calls in the back part of the dispensary to prevent people using the pharmacy from overhearing.

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.