General Pharmaceutical Council

# Registered pharmacy inspection report

## Pharmacy Name: TCP Pharma Ltd, 369 High Street, WEST BROMWICH, West Midlands, B70 9QL

**Pharmacy reference:** 1038539

**Type of pharmacy:** Community

**Date of inspection:** 04/12/2019

## Pharmacy context

This is a busy community pharmacy located on the main high street in the centre of town. It mainly dispenses NHS prescriptions and supplies some medicines in multi-compartment compliance aid packs to help make sure people take them at the correct time. It also supplies medicines to three small nursing homes. The pharmacy sells a range of over-the-counter medicines as well as offering NHS services including Medicine Use Reviews (MURs), the New Medicine Service (NMS) and a popular local minor ailments scheme. The flu vaccination is available during the relevant season and the pharmacy also offers a substance misuse treatment service.

## 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 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 not all met | 4.3 | Standard not met | The pharmacy cannot always demonstrate that it carries out sufficient checks to make sure all medicines are appropriately managed. |
| **5. Equipment and facilities** | Standards met | N/A | N/A | N/A |

## Principle 1 - Governance ✔ Standards met

### Summary findings

The pharmacy has made some improvements since the previous inspection. It identifies and manages risks adequately and keeps the records it needs to by law. Team members follow written procedures to help make sure they complete tasks safely. They work within their competence and understand how to raise concerns to protect the wellbeing of vulnerable people. But some procedures for the disposal of confidential waste are not properly followed, which could impact on patient privacy.

### Inspector's evidence

The pharmacy had a set of written standard operating procedures (SOPs) covering operational tasks and activities. Most of the procedures had been recently updated, but there were a small number with incomplete version controls, so it may not always be possible to demonstrate that procedures are up to date and reflect current practice. A master record sheet was signed by pharmacy team members confirming their acknowledgement and understanding. Team members were familiar with their roles and worked within their competence. A medicine counter assistant (MCA) was able to describe the activities which were permissible in the absence of a responsible pharmacist (RP) and in most instances two pharmacists were usually present. Professional indemnity insurance covering pharmacy services was provided through the National Pharmacy Association (NPA) and the certificate displayed was valid until May 2020.

The pharmacy kept a near miss log. During most months approximately 2-3 entries were captured, and a pharmacist said that there may be some near misses which were not recorded. The pharmacist reported that the experienced dispensers often supervised trainees, such as the pre-registration pharmacists, meaning some errors were rectified prior to reaching the accuracy checking stage. The near miss log was signed at the end of each month to confirm that entries had been reviewed and a pre-registration pharmacist discussed the separation of medication in response to a recent issue. A pharmacist discussed the actions that he would take in response to a dispensing incident and said that incidents would be reported to the superintendent pharmacist for investigation. The superintendent pharmacist said that he had reported a previous incident to the NPA but could not provide a record of this on the day.

The pharmacy had a complaint procedure. A notice explaining how concerns could be raised was displayed near to the medicine counter and concerns forms were available for completion. A team member said that people could provide verbal feedback on pharmacy services and the pharmacy also sought feedback through a Community Pharmacy Patient Questionnaire (CPPQ), which was completed annually.

The correct RP notice was conspicuously displayed near to the medicine counter. In the sample portion viewed, the time at which RP duties ceased was not routinely being recorded and there were two missing entries for 5 October 2019 and 16 October 2019, so the log was not fully compliant. Private prescription and emergency supply records were maintained but did not always record the date of supply and the date of prescription. And records for the procurement of specials did not record patient

details as an audit trail for supply. Gaps or missing details in these records could make it harder for the pharmacy to identify what has happened in the event of a query. Controlled drugs (CD) registers kept a running balance and a patient returns CD register was available.

The pharmacy had an information governance folder, which contained some information on the General Data Protection Regulation (GDPR). Team members had a general understanding of confidentiality and completed prescriptions were stored out of view. Confidential waste was shredded on the premises, but during the visit several dispensing labels containing patient identifiable data were found in a general waste bin. These were immediately removed, and the superintendent pharmacist agreed to reinforce confidential waste disposal procedures with all team members. Team members had their own NHS Smartcards. Upon arrival, the smartcard of a regular pharmacist who was currently on maternity leave was seen in a dispensing terminal. This was removed during the inspection but may indicate that smartcards are not always fully secured when not in use.

Safeguarding policies were available. A dispenser identified some of the types of concerns that she might be watching for and explained how these would be managed. The contact details of local safeguarding agencies were available to enable the escalation of concerns.

## Principle 2 - Staffing ✔ Standards met

### Summary findings

The pharmacy has a suitable staffing level to manage the current dispensing workload. The team work well together, and they can raise concerns and provide feedback. Team members have access to some ongoing learning and development, but they do not get protected training time, which may limit the ability of some individuals to keep their knowledge up to date.

### Inspector's evidence

On the day of the inspection, the superintendent pharmacist was working alongside a second regular pharmacist. The pharmacy team also comprised of two pre-registration pharmacists, three qualified dispensers and two MCAs. Another MCA arrived midway through the inspection to provide cover for the afternoon shift and a trainee team member was also present, working her first shift at the pharmacy. The superintendent pharmacist had plans to enrol the trainee on a suitable training programme within the required time frame. The pharmacy also employed two part-time dispensers, a part-time MCA and two part-time delivery drivers, none of whom were present. Leave in the pharmacy was planned and the superintendent pharmacist restricted the number of team members who could be absent at one time, to help maintain suitable staffing levels. The leave protocol had been reviewed since the last inspection, following the recruitment of additional team members. On the day there was no backlog of dispensing, all electronic prescriptions and been downloaded and placed in alphabetical order for labelling and dispensing. The team expressed that the workload was manageable, and the superintendent said that he felt the current level of staff was appropriate for dispensing but admitted that he did sometimes struggle to keep up to date with paperwork relating to the business.

Medication sales were discussed with an MCA who highlighted the questions that she would ask to make sure sales were safe and appropriate. The MCA identified co-codamol as a medication which may be considered high-risk and said that team members try to identify people who make frequent requests for such medications. Sales in the pharmacy had previously been refused, where it was felt the request was inappropriate.

Team members completed suitable training for their roles and there was some access to ongoing learning, usually through attendance at local area training events. Protected learning time in the pharmacy was not usually provided and a dispenser had experienced difficulties in completing an NVQ3 pharmacy technician programme. This was being discussed with the superintendent pharmacist and the dispenser said the training provider would also be contacted. The two pre-registration pharmacists were enrolled on a training programme with Buttercups, they attended regular study days, and said that they had additional checklists to complete during work hours to help them learn the necessary skills. The superintendent pharmacist and the other regular pharmacist were both allocated tutors and worked alongside their respective pre-registration pharmacist on a full-time basis. Regular reviews took place to monitor pre-registration progress and other team members had received some recent one-to-one feedback from the superintendent pharmacist, but records of this were not seen.

Team members had an open dialogue and the pre-registration pharmacists said that the environment

was comfortable and welcoming. Team members were happy to raise concerns and provide feedback on pharmacy services and a pharmacist confirmed that there were no set targets in place.

## Principle 3 - Premises ✔ Standards met

### Summary findings

The pharmacy provides a suitable environment 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. But the room is not easily accessible to people with mobility difficulties.

### Inspector's evidence

The pharmacy was suitably maintained, and it was generally tidy. Any maintenance concerns were addressed by the superintendent pharmacist. Pharmacy team members completed housekeeping duties and the pharmacy was seen to be clean on the day. There was adequate lighting throughout and the temperature was appropriate for the storage of medication.

The retail area appeared organised, the walkways were free from obstructions and a small number of chairs were available for use by people who were waiting for their medicines. The pharmacy stocked a range of goods that were generally suitable, but there was a small selection of sweets and carbonated drinks available, which may not be in keeping with a healthcare-based business.

The dispensary was adequately sized for the provision of services. The main dispensary had a large work bench which surrounded the room and an additional desk. There were several labelling terminals available and designated areas were used to separate dispensing and checking activities. To the side of the main dispensary was a second dispensing area which was used for the assembly of multi-compartment compliance aid packs. In this area of the dispensary was the main consultation room used by the pharmacy. Access to the room was gained by walking through the main dispensary, or by using a separate entrance door from the main high street. Both entrances required the use of steps, which may limit accessibility to the room. There was a third step-free entrance to the area via a side ramp and automatic door. The superintendent pharmacist said that this entrance had been used approximately three times, but access on the day was restricted by an overgrown branch. The room was appropriately maintained and was fitted with a desk and seating to enable private and confidential discussions. The superintendent pharmacist confirmed that in recent weeks an area in the main dispensary had been used to administer some flu vaccines, due to difficulties in some people accessing the consultation room. He reported that patients had provided consent for this. But the location of the chair and table in the main dispensary may mean that people's privacy is not always fully protected.

The pharmacy had two further consultation rooms. These were accessible from a separate entrance on the main high street and were rented for other services, including private GP consultations. The superintendent pharmacist confirmed that the pharmacy insurance providers were aware of this and the GMC registered doctor had his own personal indemnity insurance. The pharmacy had additional storage areas, office space and WC facilities which were also suitably maintained.

## Principle 4 - Services Standards not all met

### Summary findings

The pharmacy's services are generally accessible and they are suitably managed, so that people receive appropriate care. But some systems and audit trails are unclear, which may mean that the pharmacy cannot always demonstrate what has happened in the event of a query. The pharmacy sources medicines appropriately and medicines management has improved since the last inspection, but there are some outstanding areas requiring attention.

### Inspector's evidence

The pharmacy had an automatic door to facilitate access to the premises and additional adjustments could be made to help people with different needs. The pharmacy patient medication record (PMR) system could produce large print labels to help people with visual impairment and this was actively in use for two patients. Some staff members were also bilingual and utilised their skills to provide counselling and answer queries.

There was some advertisement of the pharmacy's services, including a flu poster at the front entrance. A small selection of other health promotion literature was available along with a signposting folder, and internet access to suitably direct people who required other local services.

Prescriptions were dispensed using colour coded baskets to keep them separate and reduce the likelihood of medicines being mixed up. Team members signed 'dispensed' and 'checked' boxes as an audit trail for dispensing. There were some stickers available to highlight prescriptions for high-risk medicines, but these were not always being used consistently. The superintendent pharmacist had some awareness of the risks of using valproate-based medicines in people who may become pregnant. There were some copies of the safety alert card available but other resources could not be located. The superintendent pharmacist was advised on how further copies could be obtained. Prescriptions for CDs were being highlighted with a sticker to help to make sure that supplies were made within a valid 28-day expiry date.

Patients contacted the pharmacy to order their repeat medication, the pharmacy also managed repeat ordering for some patients. A record was kept of prescriptions requested from the surgery, but team members were not always proactively reconciling the list, to identify unreturned prescriptions. This could potentially cause delays in prescription supplies. Patients who received their medicines in multi-compartment compliance aid packs were managed using a four-week cycle. A master list of patients was kept for each week. And the pharmacy kept basic audit trails of medication changes using the PMR system and discharge summaries. Compliance packs had descriptions of individual medicines and patient leaflets were supplied. A dispenser said that no high-risk medicines were placed into compliance packs. She identified some medications which would be unsuitable for use in a pack and said that she would check with the pharmacist if she was unsure.

The pharmacy supplied medicines to three local nursing homes and this process was managed by a pre-registration pharmacist. Each nursing home was contacted to identify the medications required for the month and the pharmacy submitted repeat prescription request forms. The pre-registration pharmacist kept a record of orders and followed-up on unreturned requests. Prescriptions were then dispensed using original pack dispensing. Nursing homes contacted the pharmacy to make them aware of any interim acute prescriptions or changes, which were then dispensed and sent out via the delivery driver.

Signatures were not routinely obtained for medication deliveries, except those which contained a CD, where a record book was used. A lack of audit trail may mean that the pharmacy cannot always demonstrate secure delivery and they may not always be able to show what has happened in the event of a query.

The pharmacy offered a minor ailment scheme. The treatment protocols were available in folders for reference and completed records were claimed using PharmOutcomes. An MCA was aware of some of the restrictions in place for service users.

The superintendent pharmacist verbally confirmed the training completed for the administration of the flu vaccine, but training records were not seen. Administration forms for flu vaccinations which had been completed did not always contain the full details of administration, for example, batch number, expiry date and site of administration. So, this information may not always be readily accessible if required. Equipment to aid the administration of vaccines including adrenaline and a sharps bin were available.

Stock medicines were sourced from licensed wholesalers and specials from a licensed manufacturer. Stock medications were stored in the original packaging provided by the manufacturer. There were some small areas where stock was becoming unorganised, which may increase the risk of a picking error. Date checking was carried out periodically and the pharmacy kept records of short dated medicines. Records were not always checked to make sure that expired medicines were removed from the shelves in a timely manner and some expired medicines including memantine syrup and Pulmicort inhaler were identified during random checks. The medications were immediately removed from the shelves, but this may increase the risk of expired medicines being supplied in error. Obsolete medicines were stored in medicine waste bins. The pharmacy was not yet compliant with the requirements of the European Falsified Medicines Directive (FMD). The superintendent pharmacist confirmed that he had registered with SecurMed and said that he had made a payment to a service provider for a new scanner but was still awaiting installation. Drug alerts were received via email but audit trails confirming the action taken in response were not consistently maintained. The superintendent pharmacist agreed to review this moving forward.

Both refrigerators were fitted with a maximum and minimum thermometer and were within the recommended temperature range on the day. Daily temperature records were kept for one refrigerator, but temperatures for the second refrigerator had not been kept since approximately August 2019. So, the pharmacy may not always be able to demonstrate that all thermolabile medications are suitably stored. A record for the second refrigerator was to be reimplemented following the inspection. CDs were stored appropriately. One bottle of methadone, which has a limited expiry was not marked with a date of opening. And a CD destruction which had been recently completed was not in keeping with regulations. Some expired tramadol had also not been segregated for denaturing. This indicated that the team had gaps in their knowledge around the safe management of CDs.

## 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

A range of several glass ISO approved, and crown stamped measures were available. As were counting triangles for use with loose tablets. Team members wore disposable gloves when counting loose tablets. The equipment seen on the day appeared clean and suitably maintained. The pharmacy had an up-to-date British National Formulary and internet access was available for additional research.

Electrical equipment was in working order and computer systems were password protected. Computer screens were located out of view of the medicine counter to help protect privacy and cordless phones enabled 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. |