General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Well, 1 Union Street, WEDNESBURY, West Midlands, WS10 7HD

Pharmacy reference: 1038559

Type of pharmacy: Community

Date of inspection: 17/10/2019

Pharmacy context

This is a busy community pharmacy located in the heart of the town centre. Most people who use the pharmacy are from the local area. It dispenses prescriptions and sells and range of over-the-counter (OTC) medicines as well as other health and beauty items. The pharmacy supplies medicines to two local care homes and provides medications in multi-compartment compliance aid packs to people who struggle to take them at the correct time. It offers additional services including Medicines Use Reviews (MURs), flu vaccinations and a minor ailments service. A substance misuse treatment service is also 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 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's stock is not well organised, and it cannot always demonstrate that it carries out enough checks to show that medicines are suitably stored and fit for supply.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance ✔ Standards met

Summary findings

The pharmacy identifies and manages risks adequately. It keeps people's private information safe and maintains the records it needs to by law. Its team members follow written procedures to make sure they complete tasks effectively, they act to learn from their mistakes and they raise concerns to help protect the wellbeing of vulnerable people.

Inspector's evidence

The pharmacy had a full set of written standard operating procedures (SOPs) which were available in an electronic format. The procedures had been updated within the last two years and defined the responsibilities of team members, and an audit trail was kept confirming each team members acknowledgement and understanding. A report viewed on the day showed that nearly all team members were up to date with the procedures. One member of staff, who was in her second week of employment, had recently been given access to the system and was working through them as part of an induction plan. Team members were clear on their roles, including the activities which were permissible in the absence of a responsible pharmacist (RP). The newly employed medicine counter assistant (MCA) said that if she was ever unsure she would approach a senior colleague for advice. The pharmacy had professional indemnity covering its services.

An annual audit reviewed dispensing procedures, as well as other business-related non-pharmacy topics. The most recent audit in August 2019 led to a rating of 85%. The pharmacy had been provided with several action points to address, which the pharmacist said would be verified at the next annual audit.

Pharmacy team members recorded near misses electronically. In the previous month approximately eight entries were made, and it was felt there could potentially be some entries which were not captured, which may mean that some underlying trends are not identified. The electronic system produced a dashboard which highlighted the most common near misses, and these were discussed with team members. Examples were provided of where different strengths of medicines had been separated due to similar packaging and where cautionary labels had been placed following a previous incident involving gabapentin and pregabalin. Dispensing incidents were recorded through the electronic Datix system and provided a more detailed account of what had gone wrong, as well as information on the actions that had been taken to prevent reoccurrence. All incidents were reviewed by head office and the inspector was shown examples of additional root cause analyses that had been completed in response to previous incidents.

The pharmacy had a complaint procedure and a customer notice was displayed, advising people on how they could raise a concern or provide feedback on pharmacy services. Most people provided feedback verbally to team members. The pharmacy also participated in the annual Community Pharmacy Patient Questionnaire (CPPQ).

The RP notice was conspicuously displayed near to the medicine counter and the RP log was in order. As

were specials procurement records which provided an audit trail from source to supply. Private prescriptions and emergency supply records were generally in order, but some previous entries used dispensing labels, which may be removed or fade over time and compromise the audit trail. Controlled Drugs (CD) registers kept a running balance and regular balance checks were conducted. But some headings were missing, so they were not fully compliant with requirements. A patient returns CD register was in use and previous destructions had been signed and witnessed.

Pharmacy team members completed information governance training and the company's privacy policy was clearly displayed. A dispenser discussed some of the ways in which people's private information would be protected in the pharmacy. Confidential waste was segregated and removed for appropriate disposal, completed prescriptions were stored out of public view and the appropriate use of NHS Smartcards was seen on the day.

Pharmacy team members completed annual safeguarding training and registrants had completed additional training through the Centre for Pharmacy Postgraduate Education (CPPE). They discussed some of the types of concerns which may be identified and explained how these would be managed. The pharmacist also provided an example of a concern which had been raised to protect the wellbeing of a vulnerable patient, which had led to additional support being provided. The pharmacy had a chaperone policy, which was advertised on a customer notice by the consultation room.

Principle 2 - Staffing ✔ Standards met

Summary findings

Pharmacy team members hold the appropriate qualifications for their roles. They complete ongoing learning to maintain their knowledge and skills and get feedback on their development, so they can learn and improve. The team members support one another well in a busy environment and they can provide feedback and raise concerns to improve pharmacy services.

Inspector's evidence

On the day of the inspection, the regular pharmacist was working alongside two registered pharmacy technicians and a pre-registration pharmacist, who all worked part-time in the branch. A part-time dispenser was also present, and a trainee MCA and an additional dispensing assistant arrived towards the end of the inspection. The pharmacy also employed four additional part-time dispensers, one of whom was on maternity leave and a pharmacy student on a zero hours contract provided support during university holidays. This was the usual staffing level for the day and the environment was busy. There were restrictions placed on leave to help make sure a suitable staffing level was maintained.

Over the summer months there had been an overall reduction in staffing hours at the branch. However, in recent weeks the branch had begun to make supplies to a new 57-bed care home which had significantly increased the workload in the pharmacy. Particulalry during the week of supply. Prior to this, the team reported that an audit had been conducted to ascertain whether the pharmacy had sufficient space and staffing for the increased work. However, the team felt that the impact of the work had been underestimated. And the pharmacist had escalated staffing concerns to the area manager. This had led to additional staffing hours being provided to the branch. As a result, the newly employed trainee MCA had recently commenced her part-time role and recruitment of another dispensing assistant had also recently been completed, and that individual was due to commence work in December 2019. In the interim, support was being provided through relief dispensers and double pharmacist cover had also been allocated twice a week. As a consequence, there was no backlog to the dispensing workload, but the pharmacy appeared chaotic and unorganised.

Pharmacy team members were appropriately trained for their roles and the new trainee was being enrolled on an accredited training programme. They completed ongoing training using an e-Learning system which provided updates on mandatory training modules, as well as services and OTC treatments. Training was tracked to ensure compliance and the team received regular development reviews in which they initially self-appraised their performance and then received feedback from management.

The pre-registration pharmacist worked two days a week at the branch and another three days at a nearby branch. The regular pharmacist was a co-tutor and regular reviews were held to track progress. The pre-registration pharmacist explained that her learning was supplemented with monthly study days which covered topics in the British National Formulary (BNF) as well as calculations assessments.

Pharmacy team members worked in an open culture. They supported one another well in the busy

environment and held a regular weekly huddle to discuss any issues. They were happy to approach the pharmacist with any concerns and the area manager was also contactable. The company had a whistleblowing policy and a pharmacy technician was aware of how this could be accessed through the company's intranet site. There were some targets in place for professional services. The pharmacist discussed managing the balance within the pharmacy so risks were managed along with service need. He had recently discussed targets with the area manager, following the introduction of the flu vaccination service, and he had been provided with additional support.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is suitably maintained, and it has a consultation room to enable it to provide members of the public with an area for private and confidential discussions. But space is at capacity and this impacts on general organisation and makes working conditions difficult.

Inspector's evidence

The pharmacy premises, including the external facia were suitably maintained. Any maintenance issues were directed to the company's head office and additional contracts were in place for any issues such as pest control. These contacts had been utilised recently in managing a problem with a nearby wasps' nest. Pharmacy team members completed cleaning duties. There was adequate lighting throughout the premises and an air conditioning unit helped to maintain a temperature suitable for the storage of medicines.

The retail area to the front of the pharmacy was clean and tidy. It had chairs available for use by people who were waiting for their medicines and the walkways were clear of any obstructions. The pharmacy stocked a range of suitable healthcare-based goods and pharmacy restricted medicines were secured behind the medicine counter.

Off the retail area was an enclosed consultation room. The room was clearly signposted and suitably maintained, with a desk and seating fitted to facilitate private and confidential discussions. The room was fitted with a key code lock but was unlocked on the day. A sharps bin and some adrenaline ampules were accessible in the room. This was discussed with the pharmacist, who agreed to keep the room locked moving forward, to help prevent any unauthorised access.

The dispensary in its current state was at capacity for the workload in the pharmacy. A dispensing terminal on the front bench was used for the assembly of repeat prescriptions and walk-in prescriptions, once dispensed, baskets were placed for checking on an adjacent bench used by the pharmacist. A small work bench at the rear of the main dispensary was being used to assemble medicines for the large care home and a second dispensing area provided an additional work space for the assembly of weekly compliance aid packs. At the time of the inspection all of the work benches were full of baskets of prescriptions which required checking, this impacted significantly on the dispensing space available and could increase the likelihood of mistakes. The team explained that a rear storage area had been reorganised to create an additional work area for the supplies to the care home. This currently had limited use as the pharmacy was awaiting a delivery of additional shelving units to complete the work. There were also several areas where obstructions were on the floor space which may cause a trip hazard for team members. The dispensary had a separate sink for the preparation of medicines. On the day this area was cluttered with substance misuse bottles which required cleaning and disposal. The team reported that they usually did this in batches to save time.

Principle 4 - Services **Standards not all met**

Summary findings

The pharmacy's services are generally accessible and suitably managed. But people on high-risk medicines and those using compliance aid packs may not always get all the information they need to take their medicines properly. The pharmacy obtains medicines from reputable sources. But stock medicines are not well organised and the pharmacy team should carry out more robust checks to show that medicines are appropriately stored and fit for purpose.

Inspector's evidence

Both entrances to the pharmacy had a small single-step. The team explained that the pharmacy building had a listed status and as such a ramp facility could not be added without the necessary approval. This had been discussed with the local council and had been an ongoing issue for a period of time. The provided assistance to anybody who needed help with entry. Additional support was provided for people with different needs, this included a hearing loop and the pharmacy produced large print labels to assist a patient with visual impairment.

There was some advertisement of pharmacy services throughout the retail area, using posters and service leaflets. Additional health promotion literature was also available, and the pharmacy had access to resources to support signposting. This included local contacts for services such as sharps collections and access to NHS websites.

Prescriptions were segregated into coloured baskets to prioritise the workload and keep them separate. Staff signed 'dispensed' and 'checked' boxes as an audit trail. They used stickers to highlight prescriptions for CDs, but these were not always used, which may increase the risk that a supply could be made beyond the valid 28-day expiry date. Stickers were also available to identify people on high-risk medicines so that they received additional counselling and monitoring. But records of monitoring parameters were not regularly maintained as an audit trail. The pharmacy team were aware of the risks of valproate-based medicines in people who may become pregnant. They had access to the safety literature required for supply but confirmed that they had no patients who fell within the relevant age criteria.

The pharmacy managed repeat prescriptions for a number of patients. People identified the medications which were required each month and a reorder and collection date was calculated. Repeat requests were filed in the pharmacy until due and the pharmacy kept a record to identify unreturned prescriptions and discrepancies. The same records were not kept for prescription collection patients, so some unreturned prescription requests may not be identified. Some repeat prescriptions were now dispensed at a central hub. Prescriptions were entered onto the computer system, where the information was clinically checked by the pharmacist, before being transmitted to the hub for dispensing. A record was kept identifying prescriptions being processed at the hub and upon return medications were reconciled with prescription forms and random checks were made for quality assurance. The pharmacist discussed some ongoing changes being made at the dispensing hub in

response to feedback raised by staff. Completed prescriptions were filed using a retrieval system. Prescriptions were scanned to a set location using a barcode system. Upon arriving for collection patients gave their name and the prescription location was sourced through a handheld computer. The handout procedure was discussed with the team who outlined checks that they would make, such as the patients address or date of birth. But examples were observed where these checks were not always completed. Signatures were obtained to confirm the delivery of medication. A card was left for any patient who was not in and medication was returned to the pharmacy.

Community-based multi-compartment compliance aid packs were managed using a four-week cycle. New patients requesting a compliance aid pack were assessed for need using a checklist. The pharmacy ordered repeat medications and tracked requests to make sure they were all returned. Each patient had a master list of medication which was updated to reflect any changes to medications. Completed packs were signed as an audit trail and were labelled with the patient's name. Descriptions of medications were present but were sometimes too brief to allow a medication to be identified. An example seen included a weekly pack containing two different medications which were both labelled with the description 'tablet'. Staff reported that patient leaflets were supplied, but they were not present in the completed packs which were checked on the day.

Prior to the pharmacy starting care home supplies, a risk assessment had been completed and team members had been provided with a training session to inform them how the service operated. Staff at the care home ordered the medications which were required each month. They sent a record of this to the pharmacy, and returned prescriptions were checked for any discrepancies. Medications were dispensed into individual packs which were colour coded dependent on the time of administration. Packs were then assembled onto a racking system and team members used prompt cards to record any external medications such as creams or 'when required' medications such as pain relief, that a patient may also be prescribed. Patient leaflets were supplied as were medication administration record (MAR) sheets to record administration.

The pharmacist had completed the necessary training for the administration of flu vaccines in September 2019. Training records were seen and a copy of the signed and in-date patient group directive (PGD) was available for reference. Consent forms were completed and filed, and the pharmacist had access to the necessary equipment to aid the administration of vaccinations including adrenaline and a sharps bin.

Stock medications were obtained from reputable wholesalers and specials from a licensed manufacturer. Stock medications were stored in their original packaging, but shelves were very untidy and disorganised which may increase the risk of a picking error. An electronic date checking system was in place and checks were recorded as being up to date. Short dated medicines were highlighted using stickers. However, random checks on the day identified some expired clarithromycin and Topomax, neither of which had been marked as being short dated in line with procedures. This suggests that checks are not always sufficiently robust and may increase the risk that a supply of an expired medicine could be made in error. Obsolete medicines were stored in designated waste bins for appropriate disposal. The pharmacy was not yet fully compliant with the requirements of the European Falsified Medicines Directive (FMD). A new scanner had been received into the branch, but the team had not been provided with an estimated implementation date. Alerts for the recall of faulty medicines and medical devices were received electronically. The alert system was checked throughout the day and an audit trail was kept demonstrating the action that had been taken in response to alerts.

CDs were stored appropriately. Expired and returned CDs were segregated from stock and random balance checks were found to be correct. CD denaturing kits were available. The pharmacy had three

fridges all of which were fitted with a maximum and minimum thermometer. All were within the recommended temperature range on the day. But previous temperature records for one of the fridges, used throughout the flu vaccination season could not be located on the day. So, they could not demonstrate these were stored in appropriate conditions.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide its services safely. The team uses equipment in a way that protects people's privacy.

Inspector's evidence

The pharmacy had access to paper reference texts including an up-to-date edition of the BNF. Internet access was available to support additional research. Several glass crown-stamped measures were available for measuring liquids with separate ones clearly marked for use with CDs. Counting triangles were available for loose tablets and a separate one reserved for use with cytotoxic medicines.

Electrical equipment was in working order and underwent PAT testing. Issues were escalated to the company's head office. The computer systems were password protected and screens were located out of public view. A cordless phone 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.