General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: J Docter Ltd, 73 Stubby Lane, Wednesfield, WOLVERHAMPTON, West Midlands, WV11 3NE

Pharmacy reference: 1038628

Type of pharmacy: Community

Date of inspection: 03/09/2024

Pharmacy context

This community pharmacy is in a shopping parade. It is situated in a residential area near to the town centre of Wednesfield, West Midlands. The pharmacy dispenses NHS prescriptions, private prescriptions and sells over-the-counter medicines. It also provides a range of services including the NHS Pharmacy First service and seasonal flu vaccinations. The pharmacy supplies medicines in multi-compartment compliance packs to some people to help them take their medicines at the right time.

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 not all met	1.1	Standard not met	The pharmacy does not update its written procedures to reflect changes in working practices. And team members do not always sign the SOPs to demonstrate they have understood the procedures to help make sure they know how to complete tasks correctly and safely.
		1.2	Standard not met	Near miss incidents are not reviewed to identify the root cause of the mistake for so learnings and improvements to be implemented. So there is a risk of the same mistake happening.
2. Staff	Standards not all met	2.2	Standard not met	The pharmacy does not always enrol team members on to a suitable training course required to fulfil their role safely. Which means they may not have the correct knowledge and skills to complete tasks in a safe and effective manner.
3. Premises	Standards met	N/A	N/A	N/A
4. Services, including medicines management	Standards not all met	4.2	Standard not met	The pharmacy team members do not use the available space effectively. This has led to the overcrowding of medicines and may increase the risk of a mistake happening.
		4.3	Standard not met	The pharmacy does not always store medicines correctly. Some dispensed medicines are stored on the floor and there is a risk of them becoming damaged by team members standing on them. Fridge medicines are not always stored at the correct temperature in line with requirements.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance **Standards not all met**

Summary findings

The pharmacy does not have up to date written procedures for members of the team to follow. So they may not reflect current practice to help make sure all tasks are completed safely and effectively as intended. Members of the team record when things go wrong. But they do not always look to identify the cause of the mistake so they can reflect on it and learn from them. And there is a risk of similar mistakes happening again. The pharmacy generally keeps the records it needs to by law. And the pharmacy has procedures to help keep private information safe.

Inspector's evidence

The pharmacy had a set of standard operating procedures (SOPs). But these had passed their review date in 2018, and some may not reflect current practice. For example, a hub pharmacy recently began to dispense multi-compartment compliance packs and sent them back to the pharmacy. But the procedures had not been updated to reflect this process. Some members of the team had signed the SOPs, but others had not. So team members may not always fully understand the procedures that underpin the services they were providing.

The patient medication record software had the functionality to record mistakes, such as when a dispensing error had occured. The software allowed an investigation to be recorded, and any details of learning or action taken. Near miss incidents were recorded on a paper log. The pharmacist discussed the mistakes with members of the team so they could identify learning points. But there was no analysis of the records, and the majority of actions stated, "take extra care", which did not appear to resolve the cause of the mistake. So they were not able to show how they were learning from their mistakes and taking appropriate action to reduce the risk of similar mistakes from reoccurring.

The roles and responsibilities for members of the pharmacy team were described in individual SOPs. A medicine counter assistant (MCA) explained what their responsibilities were and was clear about the tasks that could or could not be conducted during the absence of a pharmacist. The correct responsible pharmacist (RP) notice was on display. The pharmacy had a complaints procedure. Complaints could be raised with members of the team, which would be recorded and followed up by the manager. A current certificate of professional indemnity insurance was on display.

Records for the private prescriptions and unlicensed specials appeared to be in order. RP records were kept, but they did not always state when a pharmacist had ended their responsibility. So the pharmacy may not be able to accurately show when a pharmacist was present. The pharmacist acknowledged that these records need to be accurate going forwards. Controlled drugs (CDs) registers were recorded on electronic software. Running balances were recorded and checked frequently. Two random balances were checked, and both found to be accurate. Patient returned CDs were recorded in a separate register.

An information governance (IG) policy was available. When questioned, team members explained how they separated confidential information to be removed by a waste carrier. Safeguarding procedures were included in the SOPs. The pharmacist had completed level 2 safeguarding training. Members of the team were able to demonstrate they could find the contact details for the local safeguarding team. A pharmacy technician explained they would initially report any concerns to the

pharmacist on duty.

Principle 2 - Staffing **Standards not all met**

Summary findings

There are enough members of the team to manage the pharmacy's workload. But some of the team members have not completed the necessary training to ensure they have the skills and knowledge to complete tasks in the correct manner. And additional training is not routinely provided. So team members cannot show how they keep their knowledge up-to-date.

Inspector's evidence

The pharmacy team included two pharmacists, one of whom was the branch manager, two pharmacy technicians who were trained to complete accuracy checks (ACT), a trainee pharmacy technician, five dispensers, two of whom were in training, an MCA, a delivery driver, and a new starter who had began to work on the medicines counter under the supervision of another team member. There was also a member of the team who worked on a Saturday as an MCA and also helped to put dispensary stock away, but they had not completed any training. So they may not have the required knowledge to fulfil their role safely. The pharmacy was busy with regular footfall, but the team appeared to be on top of their work. Staffing levels were maintained by part-time staff and a staggered holiday system. Relief team members from nearby branches provided cover during absences.

The company had previously provided e-learning training packages. For example, some members of the team completed a Dementia Friends training pack. But further learning packages had not been provided for some time. So learning needs may not always be fully addressed and members of the team may not be able to demonstrate how they keep their skills and knowledge up to date.

An MCA gave examples of how they would sell a pharmacy only medicine using the WWHAM questioning technique, refuse sales of medicines they felt were inappropriate, and refer people to the pharmacist if needed. The second pharmacist felt able to use their professional judgement and this was respected by members of the team and the pharmacist manager. The team were seen working well with each other and assisting with any queries they had. They reported a good level of support. The team discussed their work, including when there were errors or complaints. And they were aware of the whistleblowing policy. An MCA explained how they would report any concerns to their line manager or superintendent pharmacist. There were targets for the NHS Pharmacy First service however the pharmacist did not feel under pressure to achieve these.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises generally allows services to be provided in a safe manner. But team members do not always use the available space effectively. A consultation room is available to enable private conversations with members of the team.

Inspector's evidence

The pharmacy was small, and there was little working space for dispensing activities to be carried out. To help overcome this issue, the team staggered the volume of dispensing to try and prevent overcrowding. But team members did not utilise the available space effectively to help make sure the workload was completed efficiently. People were not able to view any patient sensitive information due to the position of the dispensary. The team used electric fans to create additional airflow in the dispensary and help maintain the temperature to a suitable level. Lighting was sufficient. Members of the team had access to a kettle, separate fridge, and WC facilities. Security bars on the fire exit door had not been removed until highlighted by the inspector. Which may impede on the fire escape plan in the event of an emergency.

A consultation room was available. It contained a computer, desk, seating, and adequate lighting. The patient entrance to the consultation room was clearly signposted.

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

Summary findings

The pharmacy's services are not delivered in an efficient manner, which has caused dispensary shelves to become cluttered, and this may increase the risk of an error. Medicines are not always stored in the correct way to help ensure they are supplied in a good condition. And the team do not always check when they are handing out higher-risk medicines to ensure people take them safely.

Inspector's evidence

Access to the pharmacy was level via a single door and was suitable for those with additional mobility needs. Various posters and leaflets provided information about the services offered and various healthcare topics. The pharmacy opening hours were displayed.

The pharmacy team initialled 'dispensed-by' and 'checked-by' boxes on dispensing labels to provide an audit trail. They used baskets to separate individual patients' prescriptions to avoid items getting mixed up. The pharmacist performed a clinical check of all prescriptions and then signed the prescription form to indicate this had been completed. When this had been done, an ACT performed the final accuracy check in line with the SOPs. Owing slips were used to provide an audit trail if the full quantity could not be immediately supplied.

Stock was received from wholesalers in tote boxes. The pharmacy appeared to be holding a large amount of dispensary medicines, making the shelves cluttered and disorganised. The team ordered new stock so prescriptions could be dispensed the following day when the stock had arrived. But the new stock was being added to the dispensary shelves which were already overcrowded. This had led to the dispensary and shelving units becoming cluttered, and medicines were mixed up with each other. This had created inefficiencies in the dispensing process and increased the risk of an error occurring. The team explained they tidied the shelves as part of the date checking process. But stock quickly became untidy soon after they had completed the task.

Most dispensed medicines awaiting collection were kept in sealed bags on collection shelves. Barcode scanners were used to record the location of the bags. But a large number of bulky bags were stored on the floor. And there was a risk of the bags being stood on and being damaged. Prescription forms were retained and team members were seen confirming the patient's name and address when medicines were handed out. The pharmacist would usually write the expiry date on the prescription for schedule 3 and 4 CDs so that team members could check prescription validity at the time of supply. But a number of prescriptions were found where this had not been completed. So there is a risk this might be overlooked. The pharmacist also added notes to the prescription for any counselling advice to be provided or if a referral to the pharmacist was required. But higher-risk medicines (such as warfarin, lithium and methotrexate) were not routinely highlighted so that team members could check their latest results and whether the medicines were being used safely. Members of the team were aware of the risks associated with the use of valproate-containing medicines during pregnancy. The team only supplied original packs, and educational material with included with the medicines. The pharmacy team were not aware of any current patients who met the risk criteria.

Some medicines were dispensed in multi-compartment compliance packs. Most of the packs were assembled in an off-site pharmacy hub. The pharmacy sent details about the medicines that needed to

be dispensed to the hub after the pharmacist had completed a clinical check, and an accuracy check of the data that had been entered on to the pharmacy computer. Completed compliance packs were returned to the pharmacy for supply to the patient. Before a person was started on a compliance pack the pharmacy completed an assessment about their suitability. But this was not recorded. So the pharmacy may not be able to show the justificaiton for providing the packs to people. A record sheet was kept for each patient, containing details about their current medication. Any medication changes were confirmed with the GP surgery before the record sheet was updated. Hospital discharge information was sought, and records were retained for future reference. Compliance packs were labelled with medication descriptions. A QR barcode and hyperlink was printed on the outside of the pack so people could find patient information leaflets (PILs) for their medicines. But this was not reliable as people may not know the brand of the medicine they had been dispensed to obtain the correct leaflet.

The pharmacy had a medicine delivery service and records of deliveries were kept. Unsuccessful deliveries were returned to the pharmacy and a card posted through the letterbox indicating the pharmacy had attempted a delivery.

Medicines were obtained from licensed wholesalers, and any unlicensed medicines were sourced from a specials manufacturer. The team explained they tidied the dispensary shelves and checked the expiry dates of medicines every three weeks. But they had not kept a record to show when this had been completed. So some stock might be overlooked. Examples of short-dated stock was seen highlighted with a sticker, and liquid medication had the date of opening written onto the bottle. A spot check of medicines did not find any out-of-date stock.

Controlled drugs were stored appropriately in the CD cabinets, with clear separation between current stock, patient returns and out of date stock. There were three clean medicines fridges, each with a thermometer. The minimum and maximum temperature was being recorded daily and records showed they had remained in the required range for the last two months. But the fridges were overcrowded with stock. And two of the fridge temperatures remained above nine and ten degrees Celsius respectively during the inspection. So the pharmacy was unable to demonstrate that it stored the medicines in the correct conditions and were safe to supply. Patient returned medication was disposed of in designated bins. Drug alerts were received by email from the MHRA. Alerts were printed and the action taken was written on them, initialled and signed before being filed in a folder.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

Members of the pharmacy team have access to the equipment they need for the services they provide. And they use the equipment in a way to protect people's private information.

Inspector's evidence

Team members had access to the internet for general information. This included access to the British National Formulary (BNF), BNFc and Drug Tariff resources. All electrical equipment appeared to be in working order. There was a selection of liquid measures with British Standard and Crown marks. The pharmacy also had equipment for counting loose tablets and capsules, including tablet triangles, a capsule counter and a designated tablet counting triangle for cytotoxic medication. Equipment was kept clean.

Computers were password protected and screens were positioned so that they weren't visible from the public areas of the pharmacy. A cordless phone was available in the pharmacy which allowed team members to move to a private area if the phone call warranted privacy.

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.