General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Winer (Chemists) Ltd., 1 Bond Street, Birstall, BATLEY, West Yorkshire, WF17 9EX

Pharmacy reference: 1039394

Type of pharmacy: Community

Date of inspection: 13/01/2020

Pharmacy context

This is a community pharmacy on a parade of shops in the village of Birstall, Batley, West Yorkshire. It dispenses both NHS and private prescriptions and sells a range of over-the-counter medicines. The pharmacy team offers advice to people about minor illnesses and long-term conditions. It provides NHS services, such as the New Medicines Service (NMS) and medicines use reviews (MURs). The pharmacy provides a substance misuse service. It supplies medicines in multi-compartment compliance packs to people living in their own homes. And it provides a home delivery service to people who have difficulty collecting their medicines from the pharmacy.

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 mostly identifies and manages the risks associated with the services it provides to people. And it has a set of written procedures for the team members to follow. The pharmacy keeps the records it must have by law. And it keeps people's private information secure. The team members know when and how to raise a concern to safeguard the welfare of vulnerable adults and children. The team members openly discuss mistakes that they make when dispensing. But they do not keep up-to-date records of these mistakes. And so, they may miss out on the opportunity to learn from them and reduce the risk of similar mistakes happening again.

Inspector's evidence

The pharmacy had a good-sized retail area which led to the dispensary at the rear of the building. The pharmacy counter acted as a barrier between the retail area and the dispensary to prevent any unauthorised access. The retail area and the dispensary were open plan which allowed the team members to easily see into the retail area from the dispensary. The dispensary was set back far enough from the retail counter to allow the team members discuss confidential matters without being overheard by people in the retail area.

The pharmacy had a set of written standard operating instructions (SOPs) in place. The SOPs had an index, which made it easy to find a specific SOP. They were written by an external third-party provider and were scheduled to be reviewed every two years. But the latest scheduled review (May 2019) had not been completed. And so, the SOPs may not be up-to-date. The pharmacist explained he expected to complete the review process within the next few weeks. The pharmacy defined the roles of the pharmacy team members in each procedure. Which made clear the roles and responsibilities within the team. The team members had read and signed each SOP that was relevant to their role.

The pharmacist highlighted near miss errors made by the team when dispensing. There was a paper near miss log that the team could use to record the details of each near miss error. There were sections to record the date, time and the type of error. And other sections to record any factors that may have contributed to the error and actions the pharmacy had taken. But the log was rarely used, and no records had been made since November 2017. The team members said that their main reason for the most recent errors was because of a lack of concentration or rushing. But they did not investigate these reasons any further. The pharmacist explained he discussed near misses with the team members that were present at the time. And they discussed ways of improving their practice to reduce the risk of similar errors happening at the time. They didn't hold regular patient safety review meetings. The most common errors involved medicines that looked or sounded similar (LASAs). The team members demonstrated some separation of LASAs on the dispensary shelves which was a measure used to prevent selection errors. For example, the team members had separated losartan and levothyroxine. The pharmacy had a basic process to handle dispensing incidents that had reached the patient. But the pharmacy did not keep any records for future reference and learning. The pharmacy had recently supplied a person with 21 levothyroxine tablets instead of the correct quantity of 28 tablets. The pharmacist completed an investigation into the incident. He established that the pack of tablets supplied to the person had not been properly marked to indicate it was a split pack. The pharmacy’s normal procedure was for any split packs to be clearly marked with a pen on each side of the pack. But this process had not been followed correctly. The team members discussed this, and they were

reminded by the pharmacist to make sure the process was followed correctly in the future.

The pharmacy displayed the correct responsible pharmacist notice. So, people in the retail area could see the identity and registration number of the responsible pharmacist on duty. The team members explained their roles and responsibilities. And they were seen working within the scope of their role throughout the inspection. The team members accurately described the tasks they could and couldn't do in the absence of a responsible pharmacist. For example, they explained how they could only hand out dispensed medicines or sell any pharmacy medicines under the supervision of a responsible pharmacist. There was pharmacy task matrix in the SOP folder which detailed which tasks each team member was qualified to complete.

The pharmacy had a formal complaints procedure in place. But it was not on display for people to see. The pharmacy collected feedback each year through questionnaires that were placed on the pharmacy counter for people to self-select and complete. And the results of the most recent survey were displayed in the retail area. The results were mostly positive and 99% of people who completed a questionnaire had rated the service they received from the pharmacy as 'very good' or 'excellent'. The team members explained the most common area for improvement was the comfort of seats in the waiting area. The pharmacy had recently installed new seats with cushions.

The pharmacy had up-to-date professional indemnity insurance. Entries in the responsible pharmacist record complied with legal requirements. The pharmacy kept complete records of private prescription and emergency supplies. The pharmacy kept controlled drugs (CDs) registers. And they were completed correctly. The pharmacy kept complete records of CDs returned by people to the pharmacy. The pharmacy held certificates of conformity for unlicensed medicines and they were completed in line with the requirements of the Medicines & Healthcare products Regulatory Agency (MHRA).

The pharmacy outlined how it handled personal and sensitive data through a privacy notice in the retail area. The team members had not undertaken any training on General Data Protection Regulation (GDPR). But they were aware of the need to keep people's personal information confidential. And team members were seen offering the use of the consultation room to people or moving to a quieter area of the retail area, when discussing their health. The team held records containing personal identifiable information in areas of the pharmacy that only team members could access. Confidential waste was placed into a separate bin to avoid a mix up with general waste. The confidential waste was periodically destroyed via a third-party contractor.

The pharmacist and a pharmacy technician had completed training on safeguarding vulnerable adults and children through the Centre for Pharmacy Postgraduate Education (CPPE). When asked about safeguarding, the team members gave several examples of the symptoms that would raise their concerns in both children and vulnerable adults. The pharmacy assistant explained how she would discuss her concerns with the pharmacist on duty, at the earliest opportunity. The pharmacy had some basic written guidance on how to manage or report a concern and the contact details of the local support teams.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy team members have the appropriate qualifications and skills to provide the pharmacy's services safely and effectively. They work well together to manage their workload. And they feel comfortable to raise professional concerns when necessary. The pharmacy provides its team members with a structured training programme to help them keep their knowledge and skills refreshed and up to date. But it doesn't allocate time in the working day for them to complete this training.

Inspector's evidence

The regular full-time pharmacist was on duty during the inspection. And he was supported by a full-time NVQ level 3 qualified pharmacy technician, a full-time NVQ level 2 qualified pharmacy assistant and a full-time trainee pharmacy assistant. The pharmacy also employed another full-time pharmacy assistant and a part-time counter assistant who were not present during the inspection. One of the pharmacy assistants had recently joined the pharmacy as two team members had left the pharmacy in the last few months. The pharmacist employed a regular locum pharmacist on the days he was not working. The team members were observed managing the workload well and had a manageable workflow. The team members were seen asking the pharmacist for support, especially when presented with a query for the purchase of an over-the-counter medicine. They acknowledged people as soon as they arrived at the pharmacy counter. They were informing people of the waiting time for prescriptions to be dispensed and taking time to speak with them if they had any queries. The team members often worked additional hours to cover absences and holidays. The team members did not take holidays in the run up to Christmas to make sure the pharmacy had enough team members working, as this was the busiest time of the year for the pharmacy.

The pharmacy provided its team members with a structured training programme that was run by a third-party contractor. The team members completed various online modules. Some of which were mandatory to complete but all of them could be chosen voluntarily in response to an identified training need. A team member explained they received emails when a new module was available to complete. The latest module that the team members were required to complete was based on sore throats. There was a short quiz at the end of each module which was used to test their learning. The team members also held group discussions about current healthcare related topics. They demonstrated how they had recently watched an online video about sepsis, and they had discussed the signs and symptoms. The team members did not complete any training during the working day as they could not allocate the time to do so. They, instead, completed training in their own time.

The team members aimed to hold a team meeting every Thursday as this was the day that all the team members were working. The meetings were an opportunity for the team members to discuss and issues and ways in which they could improve the quality of the service the pharmacy was providing to people. The team members explained that they had recently changed the system of ordering prescriptions for people who had their medicines dispensed in multi-compartment compliance packs. The changes ensured the team members had extra time to dispense the person’s packs or follow up any queries with the person’s GP.

The team members felt comfortable to raise professional concerns with the pharmacist. The pharmacy did not have a whistleblowing policy. And so, the team members couldn’t raise concerns anonymously.

The team was not set any targets to achieve.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is kept secure and is well maintained. The premises are suitable for the services the pharmacy provides. It has a sound-proofed room where people can have private conversations with the pharmacy's team members.

Inspector's evidence

The pharmacy premises were spacious and suitable for the services provided. It was clean and professional in its appearance. The building was easily identifiable as a pharmacy from the outside. There was an open plan dispensing area which had plenty of bench space and storage for medicines. There were rooms on the first-floor of the building which was used for the storage of excess stock and some miscellaneous items.

Floor spaces were kept clear to minimise the risk of trips and falls. There was a clean, well-maintained sink in the dispensary for medicines preparation and staff use. There was a staff toilet with hot and cold running water and other facilities for hand washing. There was a sink in the staff area used for drink and food preparation. The pharmacy had a sound-proofed consultation room with seats where people could sit down with a team member. The room was signposted by a sign on the door, but it was untidy and cluttered with many miscellaneous items. It did not portray a professional appearance. The temperature was comfortable throughout the inspection. Lighting was bright throughout the premises.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's services are generally accessible to people. And the pharmacy mostly manages its services appropriately and delivers them safely. It provides medicines to some people in multi-compartment compliance packs to help them take them correctly. And it suitably manages the risks associated with this service. It delivers medicines to people's homes. But it doesn't ask people to sign for receipt of their medicines. So, the team may not be able to effectively answer any queries. The pharmacy sources its medicines from licenced suppliers. But the team does not regularly record the fridge temperatures. So, it cannot evidence that medicines kept in the fridge are always fit for purpose.

Inspector's evidence

The pharmacy was accessible via a step from the street to a simple push/pull entrance door. And so, people with wheelchairs or prams may have found it difficult to access the premises. The pharmacist explained he had considered using a portable ramp. But as the building was located on a hill, he was concerned that there was a risk of trips or falls. The pharmacy advertised its services and opening hours in the main window. It used a small section of the retail area to promote healthy living advice. At the time of the inspection, the area was displaying information on smoking cessation, winter health and alcohol consumption. The team had access to the internet to direct people to other healthcare services.

The team members regularly used alert stickers during dispensing, and they used these as an alert before they handed out medicines to people. For example, to highlight interactions between medicines or the presence of a fridge line or a controlled drug that needed handing out at the same time. The team members signed the dispensing labels when the dispensing and checking processes were complete. And so, a robust audit trail of the process was in place. They used baskets to hold prescriptions and medicines. This helped the team members stop people's prescriptions from getting mixed up. They used a 'CD' stamp to highlight prescriptions for a CD that was not required to be stored in the CD cabinet. This system helped the team members check the date of issue of the prescription and helped prevent them from handing out any CDs to people after their prescription had expired. Owing slips were given to people on occasions when the pharmacy could not supply the full quantity prescribed. One slip was given to the person. And one kept with the original prescription for reference when dispensing and checking the remaining quantity. The pharmacy kept records of the delivery of medicines it made to people. The records did not include a signature of receipt. So, there was no audit trail that could be used to solve any queries.

The pharmacy supplied medicines in multi-compartment compliance packs for people living in their own homes. And the pharmacy supplied the packs to people on either a weekly or monthly basis. The team was responsible for ordering people's prescriptions. And this was done around two weeks in advance to give the team members the time to resolve any queries, such as missing items or changes in doses, and to dispense the medication. They dispensed the packs on a bench that was furthest away from the pharmacy counter. This was to minimise distractions. The pharmacy managed the workload across four weeks. And it kept all documents related to each person on the service in separate wallets. The team members used progress charts which helped the team visually assess the progress of the dispensing. The documents included master sheets which recorded the person's current medication and times of administration. The team members used these to check off prescriptions and confirm they were accurate. They supplied the packs with information which listed the medicines in the packs and

the directions. And information to help people visually identify the medicines. For example, the colour or shape of the tablet or capsule. It also routinely provided patient information leaflets with the packs.

The pharmacy dispensed high-risk medicines for people such as warfarin, lithium and methotrexate. The team members used green 'pharmacist' stickers which were attached to people's prescriptions as a reminder to discuss the person's treatment when handing out the medicine. The pharmacist explained he did some basic checks with people when they came to collect their medicines. These included ensuring the person had had a recent blood test and checked their current and target INR if they were prescribed warfarin. The team members were aware of the pregnancy prevention programme for people who were prescribed valproate and of the risks. They demonstrated the advice they would give people in a hypothetical situation. And there was a poster displaying information about the programme attached to a dispensary wall. The team members had access to literature about the programme that they could provide to people to help them take their medicines safely. The pharmacist explained he had identified two regular patients who were prescribed sodium valproate. And he explained to them the risks of becoming pregnant while taking sodium valproate.

Pharmacy medicines were stored behind the pharmacy counter. Which prevented people from self-selecting the medicines. Every three months, the team members checked the expiry dates of its medicines to make sure none had expired. But the team were unable to locate any records of the check. Following the inspection, the pharmacist sent the inspector records of the checks that had been completed in 2019. The records showed the pharmacy was regularly date checking its stock. One out-of-date medicine was found after a random check of around thirty medicines. The team members did not always record the date liquid medicines were opened on the pack. So, they couldn't always check they were in date and safe to supply. The pharmacy had a robust procedure in place to appropriately store and then destroy medicines that had been returned by people.

The team was not currently scanning products or undertaking manual checks of tamper evident seals on packs, as required under the Falsified Medicines Directive (FMD). The team had not received training on how to follow the directive, but it had the correct type of scanners and software installed. Drug alerts were received via email to the pharmacy and actioned. The team did not keep a record of the action it had taken. The pharmacy used a digital thermometer which recorded the fridge temperature and the records could be downloaded and printed off as a report. But the team members couldn't do this during the inspection. And had no records available. The importance of checking fridge temperatures each day was discussed with the team. The pharmacist explained he would start recording the fridge temperatures daily with immediate effect. Following the inspection, the pharmacist sent the inspector up-to-date fridge temperature records. The records showed the fridge temperature being recorded each day, including the day of the inspection. And they were within the correct ranges. The medicines inside the fridge and CD cabinets were well organised.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy's equipment is well maintained and appropriate for the services it provides. The pharmacy uses its equipment to protect people's confidentiality. But some confidential material is kept in the consultation room. And the material may be seen by people using the room.

Inspector's evidence

The pharmacy had copies of the BNF and the BNF for children for the team to use. And the team had access to the internet as an additional resource. The pharmacy used a range of CE quality marked measuring cylinders. The team members used tweezers and rollers to help dispense multi-compartment compliance packs. The fridge used to store medicines was of an appropriate size. Prescription medication waiting to be collected was stored in a way that prevented people's confidential information being seen by members of the public. And computer screens were positioned to ensure confidential information wasn't seen by unauthorised people. The computers were password protected to prevent any unauthorised access. The pharmacy had cordless phones, so the team members could have conversations with people in private. But some confidential material, for example prescriptions, were kept in plain sight in the consultation room. And so, there was a risk that people's confidentiality may be compromised. This was discussed with the team. And the pharmacist explained he would make arrangements to remove the confidential information from the room following the inspection.

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.