General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Mileusnic Chemist, 133 Upper Commercial Street, BATLEY, West Yorkshire, WF17 5DH

Pharmacy reference: 1039404

Type of pharmacy: Community

Date of inspection: 24/05/2019

Pharmacy context

This is a community pharmacy on a shopping parade with several other local shops. The pharmacy sells over-the-counter medicines and dispenses NHS and private prescriptions. The pharmacy offers advice on the management of minor illnesses and long-term conditions. It also supplies medicines in multi-compartmental compliance packs to people living in their own homes.

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 has suitable procedures for the team to follow to help manage risks to its services. And it asks people for their views about its services in an annual survey. The pharmacy keeps the records it must by law. But it doesn't regularly check the accuracy of some of these records. So, it may not identify errors the team might make. The pharmacy team members have a good knowledge about how to protect the welfare of children and vulnerable adults. They generally keep people's private information safe. The pharmacy's team members record and discuss errors that happen with dispensing. They sometimes use this information to learn and make changes to help prevent similar mistakes happening again. But, they don't always record all the details of why errors happen. So, they may miss out on learning opportunities.

Inspector's evidence

The pharmacy had a set of standard operating procedures (SOPs). These provided the team with information on how to perform tasks supporting the delivery of services. The SOPs covered procedures such as taking in prescriptions and dispensing. The team members were seen working in accordance with the SOPs. The SOPs were due for review in July 2018 but this had not been completed. And so the content may have been out of date. Each team member had signed the SOPs that were relevant to their role. The pharmacy defined the roles of the pharmacy team members in each SOP. The SOP showed who was responsible for performing each task. The team members said they would ask the pharmacist if there was a task they were unsure about or felt unable to deal with.

The pharmacy had a process in place to report and record near miss errors that were made while dispensing. The pharmacist typically spotted the error and then let the team member know they had made an error. The team member identified what had happened to help them reflect on why it occurred and to help with their learning. The team members were encouraged to record details of their own errors on to a log. But the pharmacist often made the record. The records included the time and date of the error. But the team didn't regularly record the causes of the errors. The error logs were analysed each month either by a dispenser or one of the two regular pharmacists. This was done to see if there were any patterns or common trends in the errors. Details of the analysis were documented and filed for future reference. The team discussed the findings of the analysis each month in a team meeting. The team discussed LASA (look-a-like, sound-a-like) medicines during the last meeting. The team found that they were sometimes mixing up these medicines when they were dispensing for example amitriptyline and amlodipine. They decided to separate these medicines to reduce the risk of the errors happening again. And the number of similar errors had reduced. The pharmacy recorded details of dispensing incidents electronically. The team printed off the record for future reference.

The pharmacy had a complaints procedure in place. But this was not advertised to people. So, people may not be able to raise concerns or make a formal complaint. The pharmacy organised an annual survey to establish what people thought about the service they received. But they could not give an example of how they had improved the services they offered after feedback that had been received.

The pharmacy had appropriate professional indemnity insurance facilities. The responsible pharmacist notice displayed the correct details of the responsible pharmacist on duty. The pharmacists did not

always record the time their duties had ended in the responsible pharmacist register. This is not in line with requirements.

A CD destruction register for patient returned medicines was correctly completed. The pharmacy maintained complete records for private prescriptions. The pharmacy retained completed certificate of conformities following the supply of an unlicensed medicine.

The team members destroyed confidential waste immediately. And they stored prescription medication waiting to be collected, in a way that prevented people's confidential information being seen by members of the public. Several bags containing dispensed medicines and personal details of people were stored in the consultation room. And so there was a risk that the details could be seen by people who used the room.

The two regular pharmacists had completed training via the Centre for Pharmacy Postgraduate Education (CPPE) on safeguarding the welfare of vulnerable people. All other team members had completed training via the Kirklees safeguarding board. The team members gave several examples of symptoms that would raise their concerns. And they said they would discuss their concerns with the pharmacist on duty, at the earliest opportunity. The contact details of the local safeguarding board leads were displayed in the dispensary. The pharmacy had a flow chart available which outlined how team members should handle and manage a concern.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy team members have the right qualifications and skills for their roles and the services they provide. They complete training to keep their knowledge up to date. But, they do not regularly reflect on their own performance. And, they don't have a formal process to discuss their performance or individual training needs. So, it may be difficult to tailor learning to make sure they have the skills for their roles.

Inspector's evidence

One of two regular pharmacists was on duty at the time of the inspection. And he was also the superintendent pharmacist. The pharmacist was supported by three full-time NVQ2 qualified pharmacy assistants. The pharmacy also employed a delivery driver. The pharmacist worked three days a week. The second regular pharmacist covered the remaining days. The team were observed supporting each other during the inspection. And managing the workload well. The two pharmacists organised a few hours during the week when they worked alongside each other. This time was used for them to discuss staff rotas, analyse the error logs and manage other administrative tasks. The team members were able to work overtime to cover any planned or unplanned absences.

The pharmacist on duty supervised the team members. And they involved the pharmacist in offering advice to people who were purchasing over-the-counter products for various minor ailments. They carried out tasks and managed their workload in a competent manner. And they asked appropriate questions when selling medicines that could only be sold under the supervision of a pharmacist. The team members accurately described the tasks that they could and could not perform in the pharmacist's absence.

The team members said that they were actively encouraged to continue ongoing learning. The team members completed learning about pharmacy related topics such as medicines and health conditions through reading trade press materials and discussing the topics with colleagues. The team members said that they tried to complete training during quieter periods of business. But this was not always possible and so they completed most of their training in their own time.

The team members did not receive a formal performance appraisal. The pharmacy's owners informed the team of how they were performing through open conversations or in a team meeting. The team meetings were also a chance for the team members to raise and concerns or give feedback on how they could improve the services provided. The team said that they had given feedback to the pharmacy owners about which items should be sold in the pharmacy and which should not. The team said that any concerns would be raised openly during the team meetings. But a whistleblowing policy was not in place. So, the team members may not be able to raise a concern anonymously.

The team were asked to meet various targets. These included retail sales, prescription volume and the number of medicine use review (MUR) and New Medicines Service (NMS) consultations completed. The team said that they did not feel under pressure to achieve the targets. And would only try to deliver a service if it was in the best interest of the person.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is small and it is difficult to find enough space for storage. This may increase the risk of trips and falls. The pharmacy is adequately maintained. The pharmacy's facilities allow people to have private conversations with the team.

Inspector's evidence

The pharmacy was small for the services provided. It was professional in appearance, generally clean, hygienic and well maintained. Several bags of dispensed medication and boxes of medicine deliveries were stored on the dispensary floor. This presented several trip hazards. There was a clean, well maintained sink in the dispensary used for medicines preparation and staff use. There was a WC which provided a sink with hot and cold running water and other facilities for hand washing. The area was free of clutter.

The pharmacy had a signposted and sound proofed consultation room which contained adequate seating facilities. Temperature was comfortable throughout inspection. Lighting was bright throughout the premises.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides services to help people meet their health needs. It mostly stores and manages medicines safely. The pharmacy supplies some people's medicines in multi-compartmental compliance packs. But it doesn't always provide patient information leaflets with the packs. And it doesn't include descriptions of the medicines inside the packs. And so, people may find it difficult to visually identify the medicines. And they may not receive the information they need to help take their medicines safely.

Inspector's evidence

The pharmacy was accessible via a step from the street. A ramp was not available. So, not all people, e.g. wheelchair users, could access the premises easily. The services on offer, and opening times were advertised in the front window. There were adequate seating facilities for people waiting for prescriptions. Large print labels were provided on request. The team members had access to the internet. Which they used to signpost people requiring a service that the team did not offer. A small range of healthcare related leaflets were available for people to select and take away.

The pharmacy had an audit trail for dispensed medication. The team achieved this by using dispensed by and checked by signatures on dispensing labels. The dispensary had a manageable workflow with separate, areas for the team members to undertake the dispensing and checking parts of the dispensing process. A narrow bench was used to dispense the multi-compartmental compliance packs. The team members used baskets to hold prescriptions and medicines. This helped the team to stop people's prescriptions from getting mixed up. But, they did not highlight bags of dispensed medicines containing controlled drugs (CD). So, there was a risk that CDs might be supplied after the prescription had expired.

The team occasionally identified people who were prescribed high-risk medication such as warfarin. And they were given additional verbal counselling by the pharmacist. The team knew about the pregnancy prevention programme for people who were prescribed valproate. The team said that they knew about the risks and they demonstrated the advice they would give people in a hypothetical situation. The team had access to leaflets and alert cards which were about the programme and they gave these to any people who would benefit from information about the programme. The team had identified two regular people who they dispensed prescriptions for and who may have been at risk. The pharmacist had contacted each of these people and given them appropriate advice.

People could request for their medicines to be dispensed in multi-compartmental compliance packs. And these were supplied to people on a weekly basis. The team were responsible for ordering the person's prescription. And they did this around a week in advance, so it had ample time to manage any queries. And then the prescription was cross-referenced with a master sheet to ensure it was accurate. The team queried any discrepancies with the person's prescriber. The team recorded details of any changes, such as dosage increases and decreases, on the master sheet. The team supplied the packs with backing sheets which contained dispensing labels. But they did not provide any information which would help people visually identify the medicines. The team did not always supply patient information leaflets with the packs.

The pharmacy kept basic records of the delivery of medicines from the pharmacy to people. The

records did not include a signature of receipt. So, it would be difficult to resolve any queries or errors. The pharmacy supplied people with a note when a delivery could not be completed advising them to contact the pharmacy.

The pharmacy gave people owing slips when it 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 team attempted to complete the owing the next day.

The pharmacy stored pharmacy only medicines behind the retail counter. These medicines could only be sold in a pharmacy, and under the supervision of a pharmacist. The storage arrangement prevented people from self-selecting these medicines.

The team were scheduled to check the expiry dates of the stock every three months. And the team kept records of the activity. But the team did not always keep to the schedule. The team completed the last check in May 2019. No out of date stock was found following a random check. The team used stickers to highlight medicines that were expiring in the next 6 months. The team recorded the date the pack was opened on liquid medicines. This allowed them to identify medicines that had a short-shelf life once they had been opened and check that they were fit for purpose and safe to supply to people. The team were not currently scanning products or undertaking manual checks of tamper evident seals on packs, as required under the Falsified Medicines Directive (FMD). No software, scanners or a SOP were available to assist the team to comply with the directive. The team had not received any training on how to follow the directive.

The team members checked and recorded fridge temperatures each day. A sample seen was within the correct ranges.

The pharmacy obtained medicines from several reputable sources. It received drug alerts electronically and the team actioned them as soon as possible. The team members printed the alerts and stored them in a folder. They kept a record of the action they took following the recall.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The equipment the pharmacy uses in the delivery of its services is clean, safe and protects people's confidentiality.

Inspector's evidence

References sources were in place. And the team had access to the internet as an additional resource. The resources included hard copies of the current issues of the British National Formulary (BNF) and the BNF for Children. The pharmacy used a range of CE quality marked measuring cylinders. Tweezers and rollers were available to assist in the dispensing of multi-compartmental compliance packs. The fridges used to store medicines were of appropriate sizes. Medicines were organised in an orderly manner. The computers were password protected and access to peoples' records were restricted by the NHS smart card system. And computer screens were positioned to ensure confidential information wasn't on view to the public. The computers were password protected. Cordless phones assisted in undertaking confidential conversations.

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.