

Registered pharmacy inspection report

Pharmacy Name: J Docter, 67 Rupert Street, BIRMINGHAM, West Midlands, B7 5DT

Pharmacy reference: 1078893

Type of pharmacy: Community

Date of inspection: 04/07/2019

Pharmacy context

This community pharmacy is located along a parade of shops and is close to a dental practice. It mainly dispenses NHS prescriptions that it receives from two local surgeries. The pharmacy supplies some medicines in multi-compartment compliance packs to help people take their medicines. The pharmacy also provides Medicines Use Review (MUR) consultations.

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 generally manages its risks adequately. Its team members make changes to the dispensing service to improve its safety. They keep the legal records that are needed and generally make sure that they are accurate. The pharmacy's team members handle people's personal information properly. And they know how to protect vulnerable people.

Inspector's evidence

The pharmacy regularly asked people visiting the pharmacy to complete satisfaction surveys. The previous survey's results were positive. Team members said that people also provided verbal feedback. They said that complaints would be escalated to the pharmacist or superintendent pharmacist to resolve.

The pharmacy's team members had completed training about safeguarding vulnerable people. Some team members had completed additional training through the Centre for Pharmacy Postgraduate Education (CPPE). The pharmacist said that safeguarding training was required to provide the local sexual health service. He said that there had been no previous safeguarding concerns. He said that he could locate the contact details for local safeguarding organisations on the internet.

Confidential waste was separated from other waste so that it could be shredded. Team members were trained about information governance and confidentiality. They had their own NHS smartcards which were used to access electronic prescriptions. The pharmacist said that he had received additional training to access people's NHS Summary Care Records. He said that he would only access these when necessary and with appropriate consent of the person.

The pharmacy had standard operating procedures (SOPs) which covered its services. The SOPs were annotated to show when they had last been reviewed. Several SOPs had last been reviewed in 2014. This was confirmed by the pharmacist and meant that some procedures may not have reflected the pharmacy's current practice. The pharmacist said that there had been some updates so that the team were aware about changes to legislation. He said that SOPs were in the review process. Most team members had signed the SOPs to show they had read them. The pre-registration pharmacy student had not signed the SOPs but said that he had read them.

The pharmacy recorded near misses from the dispensing process. Team members said that dispensers generally recorded their own mistakes. Records included information about the medicines and team members involved, but it did not usually include information about contributing factors. Team members said that individual mistakes were discussed, and actions taken to reduce the chance of reoccurrence. This included separating different strengths or formulations of the same medicine. There was limited trend analysis that occurred, so the team may have been missing some learning opportunities. The pharmacy completed annual patient safety reviews which included information about near misses and dispensing errors.

Certificates were displayed which showed that there were current arrangements for employer's liability, public liability and professional indemnity insurance. The pharmacy kept required controlled drug (CD) records. The records included CD running balances. Two CDs were chosen at random and the

stock matched the recorded running balances. Records about private prescriptions were generally adequate but there were several records that included the incorrect prescription date or prescriber. This meant it may have been more difficult for the pharmacy to find these details. Other records about the responsible pharmacist, returned CDs, unlicensed medicines and emergency supplies were kept and maintained adequately.

Principle 2 - Staffing ✓ Standards met

Summary findings

The pharmacy has enough staff to safely provide its services. Its team members have suitable pharmacy qualifications and competently complete tasks. They know when it is appropriate to refer to the pharmacist. The pharmacy's team members receive some ongoing training to keep their knowledge up to date.

Inspector's evidence

At the time of the inspection there was the responsible pharmacist (pharmacy manager), one pre-registration pharmacy student, two dispensers and one medicine counter assistant present. This staffing level appropriately managed the pharmacy's workload. The pharmacist said that the team members' annual leave was organised to maintain an adequate staffing level. He said that the pharmacy had other branches which he could contact if he needed more support with staffing.

The pre-registration pharmacy student described training that he received to prepare for his exam. This included online and face-to-face training with a third-party company. He said that he also was supported by the pharmacist when he had queries or questions. Certificates were displayed which showed that other team members had pharmacy qualifications that were appropriate to their role. A dispenser was training towards a further qualification, so she could become NVQ level 3 qualified. The pharmacist described his role in supporting this training. This included signing-off statements about experiences that the dispenser had undertaken in the pharmacy. The pharmacist said that some team members had completed a course about promoting healthy living. The pharmacy's team members had access to training booklets which they received every four to six weeks. Previous topics included hay fever and winter health. Team members said that they were encouraged to read the booklets and sometimes did this during their lunch break. They said that there was no time set aside for completing this training which may have made it difficult for them to complete it regularly.

Team members were clear about their roles and issues that would need to be referred to the pharmacist. They said that they used informal discussions to share messages. They said that feedback about their performance was provided during informal discussions with the pharmacist. The pharmacy had targets. The pharmacist said that he did not feel pressured to achieve targets and felt well-supported by the superintendent pharmacist.

Principle 3 - Premises ✓ Standards met

Summary findings

The pharmacy safely provides its services from suitable premises. It has enough space to safely manage its workload and its team members keep the premises clean and tidy. The pharmacy has appropriate security arrangements to protect its premises.

Inspector's evidence

The pharmacy was clean and tidy. The pharmacy's retail area and dispensary were adequately sized to safely manage its workload. Team members kept workbenches tidy so that there was enough space to safely complete tasks. There was adequate heating and lighting throughout the pharmacy. The pharmacy had hot and cold running water available. The pharmacy had a consultation room which was suitable for private consultations and conversations. And it had appropriate security arrangements to protect its premises.

Principle 4 - Services ✓ Standards met

Summary findings

The pharmacy generally manages its services adequately. It makes sure that its services are organised and provided safely. It stores its medicines appropriately and makes sure that they are safe to use. The pharmacy's team members identify higher-risk medicines and largely provide appropriate advice to help people use their medicines safely.

Inspector's evidence

The pharmacy's layout and step-free access increased its accessibility to people in wheelchairs. There were no leaflets in the retail area which provided information about the pharmacy and its services. This may have restricted people's access to this information. The pharmacy was listed on the company website (jdocter.co.uk) which provided information about the pharmacy and its services. People could register on the website to have their prescription collected from their GP surgery. However, the pharmacist said that this was not used by people who visited the pharmacy. A team member was able to speak Somali which was the preferred language of a large proportion of people who used the pharmacy. He said that people often brought a relative or other advocate if they could not communicate well in English.

The pharmacy ordered some people's prescriptions from local GP surgeries. It kept records about the prescriptions that it ordered. Team members said that most prescriptions were received electronically 48 hours after ordering. Dispensers used baskets to make sure prescriptions were prioritised and medicines remained organised. Computer-generated labels contained relevant warnings and were initialled by the dispenser and checker to provide an audit trail. The pharmacy's dispensing software highlighted interactions to the team. Team members said that they verbally informed the pharmacist about interactions or printed warning labels when needed. Prescriptions were kept with dispensed medicines awaiting collection. Team members said they would check prescription dates to make sure medicines were supplied while prescriptions remained valid. They said that dispensed prescriptions would be stored in a separate area if there was a query that needed to be resolved or discussed. Team members said that notes were sometimes attached to checked medicines to make sure counselling points were provided to people.

The pharmacy's team members said that they asked people about relevant blood tests if they saw that higher-risk medicines were being supplied. They were aware about pregnancy prevention advice to be provided to people in the at-risk group taking sodium valproate. The pharmacy had up-to-date versions of guidance materials. The pharmacy delivered some people's medicines. It kept records about these deliveries, but most records did not include the recipient's signature. This meant it may have been more difficult for the pharmacy to know that deliveries had been completed correctly.

The pharmacy supplied medicines in multi-compartment compliance packs to some people to help them manage their medicines safely. A dispenser said that prescriptions were ordered around three weeks in advance so there was enough time to assemble the packs. The pharmacy kept records about the medicines inside the packs and their administration times. The pharmacist kept records about changes to medicines that had been made by GP surgeries or hospitals. Both dispensers were able to complete the prescription ordering process for the packs. The packs were largely assembled by a robot that was located off-site. Assembled packs included the dispensing date and the photograph of the medicine so it could be easily identified. Team members said that the pharmacist completed clinical

checks of the prescriptions before it was sent to the robot. They said that the packs were generally sent to the pharmacy a week after the prescriptions were sent. A dispenser said that urgent packs could be sent to the pharmacy more quickly. Team members said that people received patient information leaflets when they first received a compliance pack or if they received a new medicine in the pack. This may have restricted people's access to up-to-date information about their medicines. This was highlighted to the pharmacist so that the pharmacy could start regularly providing these leaflets.

The pharmacy kept invoices which showed that its medicines were obtained from licenced wholesalers. It had a fridge that was used for medicines that needed cold storage. It kept records about daily fridge temperatures so that it could make sure the medicines were kept at the right temperatures. CDs were stored appropriately. Expired CDs were separated from other stock.

The pharmacy kept records about medicines that were approaching their expiry within six months. These medicines were also highlighted with stickers. The pharmacy kept records about expired medicines. The pharmacy labelled the date onto medication bottles when they were opened. This helped the team members to know that the medicine was suitable if they needed to use it again. Expired and returned medicines were segregated and placed in to pharmaceutical waste bins. These bins were kept safely away from other medicines. A separate bin was used to segregate cytotoxic or hazardous medicines. A list was displayed to help identify these medicines.

The pharmacy had scanners to help verify its medicines' authenticity in line with the Falsified Medicines Directive. The pharmacist said the pharmacy's software was currently being upgraded so that it could perform the required processes. The pharmacy received information about medicine recalls. It kept records about recalls it had received and the actions that had been taken. This included a recent recall about paracetamol tablets.

Principle 5 - Equipment and facilities ✓ Standards met

Summary findings

The pharmacy has the right equipment to provide its services safely. It keeps its equipment and facilities in adequate condition. And it makes sure confidential information is protected.

Inspector's evidence

The pharmacy's equipment appeared to be in good working order and maintained adequately. Team members said that they escalated maintenance issues to the pharmacist and superintendent pharmacist. The team provided an example of a recent issue that had been resolved. Confidential information was not visible to people using the pharmacy. Computers were password protected to prevent unauthorised access to people's medication records. The sinks had running hot and cold running water. Crown-stamped measures were used to accurately measure liquids. There were separate measures for CDs. The pharmacy had suitable equipment to count loose tablets. It had access to the internet and it had up-to-date reference sources.

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.