General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Scales Pharmacy, 37-38 Upper Tything, WORCESTER, Worcestershire, WR1 1JZ

Pharmacy reference: 1079794

Type of pharmacy: Community

Date of inspection: 08/04/2019

Pharmacy context

The pharmacy is a community pharmacy located on a busy road in a parade of small local shops. It is close to Worcester city centre. The pharmacy sells over-the-counter medicines and dispenses NHS prescriptions. It also supplies medicines in multi-compartment devices to assist vulnerable people living in their own homes to take their medicines.

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	2.4	Good practice	The staff are encouraged to keep their skills up-to-date.
		2.5	Good practice	The team members are well supported. They are comfortable about providing feedback to their managers and this is acted on.
3. Premises	Standards met	N/A	N/A	N/A
4. Services, including medicines management	Standards met	4.2	Good practice	The pharmacy team make sure that people have the information that they need to use their medicines safely and effectively. They intervene if they are worried and escalate any concerns to their doctors.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance ✔ Standards met

Summary findings

The pharmacy team identify and manage risks satisfactorily. The pharmacy is tidy and organised. But, the team could learn more from mistakes to prevent them from happening again.The pharmacy team keep people's private information safe. But, people can be seen in the consultation room and so any consultations in here may not be confidential. The pharmacy is appropriately ensured to protect people if things go wrong. The team keep the up-to-date records that they must keep by law.The staff know how to protect the welfare of vulnerable people.

Inspector's evidence

The pharmacy staff identified and managed most risks. Any dispensing errors and incidents were reported to be recorded, reviewed and appropriately managed. Near misses were recorded but there were only two recorded entries for the whole of February. The information was recorded electronically and so, for this to be done, the person on the computer had to stop labelling to record the information.

This may not encourage the recording of all near misses and may account for the low recording. One of the errors documented, ramipril capsules picked instead of tablets, did include the learning point of not assuming the common form, capsule, had been prescribed. However, no actions were documented to reduce the likelihood of similar recurrences, such as highlighting unusual forms on the prescription. The log was not documented as being reviewed and was not discussed with the staff at the end of a set period.

The dispensary was spacious and organised. There were clear labelling, assembly and checking areas. There was also a small monitored dosage system area. But, upstairs there was a lot of underutilised space which could be used for a separate, spacious area for the MDS trays. This would reduce the likelihood of distractions and hence errors.

Coloured baskets were used but only distinguished prescriptions for patients who were waiting or those with repeat prescriptions. Prescriptions for patients who were calling back or those for delivery, were not distinguished by different coloured baskets. This denied the pharmacist the ability to effectively prioritise his workload. There was a clear audit trail of the dispensing process and all the 'dispensed by' and 'checked by' boxes on the labels examined had been initialled. Any prescriptions checked by the accuracy checking technician (ACT) had been clinically checked by the pharmacist prior to this and there was a clear audit trail demonstrating this.

Up-to-date, signed and relevant Standard Operating Procedures (SOPs), including SOPs for services provided under patient group directions were in place and these were reviewed every two years, or sooner, if necessary, by the Superintendent Pharmacist. The roles and responsibilities were set out in the SOPs and the staff were clear about their roles. There was no displayed sales protocol. A newly appointed medicine counter assistant (MCA) trainee, still in her probation period, said that she would refer any requests for 'pharmacy only' (P) medicines to the pharmacist. A NVQ2 trained dispenser was aware of 'prescription only' (POM) to 'P' switches such as Viagra Connect and would refer requests for these to the pharmacist. She knew that fluconazole capsules should not be sold to women over 60 for

the treatment of vaginal thrush. All the staff referred requests for veterinary medicines to the pharmacist.

The staff were clear about the complaints procedure and reported that feedback on all concerns was encouraged. The pharmacy did an annual customer satisfaction survey. In the 2018 survey, 100 % of customers who completed the questionnaire were satisfied with the service from the pharmacy. But, the printed and displayed results did not include any improvements made by the pharmacy following feedback. There had been some feedback about the signposting to the consultation room. There was signposting to the consultation room but this was not prominent and other displayed posters distracted from this.

Current public liability and indemnity insurance provided by the National Pharmacy Association (NPA) and valid until 30 September 2019 was in place. The Responsible Pharmacist log, controlled drug (CD) records, including patient-returns, private prescription records, emergency supply records, specials records, fridge temperature records and date checking records were all in order.

There was an information governance procedure and the staff had also recently completed training on the new data protection regulations. The computers, which were not visible to the customers, were password protected. Confidential information was stored securely. Confidential waste paper information was shredded. No conversations could be overheard in the consultation room.

The staff understood safeguarding issues. The pharmacist and technician had also completed the Centre for Pharmacy Postgraduate Education (CPPE) module on safeguarding. Local telephone numbers were available to escalate any concerns relating to both children and adults. All the staff had completed ‘Dementia Friends’ training.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy generally has enough staff to manage its workload safely. But, sometimes team members must do duties which take them away from the pharmacy which could leave the pharmacy short-staffed at times. The staff are encouraged to keep their skills up-to-date and they do this in work time. The team members are well supported. They are comfortable about providing feedback to their managers and this is acted on.

Inspector's evidence

The pharmacy was on a busy road close to Worcester city centre. They dispensed approximately 8000 NHS prescription items each month with the majority of these being repeats. 90 domiciliary patients received their medicines in monitored dosage systems (MDS). Few private prescriptions were dispensed.

The current staffing profile was one pharmacist, one full-time (FT) accuracy checking technician (ACT) but she was on driving duties on the day of the visit because of staff shortages, 2 FT NVQ2 trained dispensers and one FT MCA trainee (still in her induction period).

The staffing profile allowed little flexibility to accommodate either planned or unplanned absences. The company as a whole, three branches, had suffered some staff shortages recently. Four members of staff had left. As mentioned above, the ACT was on driving duties on the day of the visit. The pharmacy had recruited a MCA trainee, but she was only in her second week of employment. The company had no relief dispensers and locum dispensers were not employed. Planned leave was booked well in advance and only one member of the dispensary staff could be off at one time. But, the staffing hours were not back-filled. When the ACT was off, she was not replaced with an ACT.

Staff performance was monitored, reviewed and discussed informally throughout the year. There was an annual performance appraisal where any learning needs could be identified. Review dates would be set to achieve this. The staff were encouraged with learning and development and completed monthly 'Virtual Outcomes' e-learning, such as recently on bowel cancer. This was done in work time when it was quiet. There was no dedicated training rota. The newly appointed MCA trainee said that she believed that she would have allocated work time towards her course. The pharmacist said that he would set up a formal training rota. The dispensary staff reported that they were supported to learn from errors. The pharmacist said reported that all learning was documented on his continuing professional development (CPD) records, such as recently on the Falsified Medicines Directive (FMD).

The staff knew how to raise a concern and reported that this was encouraged and acted on. They all said that they were well supported by their manager. The staff had recently raised an issue with him about pay rises. The manager had escalated this to the Superintendent who had acted on this. 'Ad hoc' staff meetings were held when deemed necessary. The pharmacist said that he would introduce more formal monthly meetings.

The pharmacist reported that he was set overall targets, such as 400 annual medicine use reviews (MURs). He said that he only did clinically appropriate reviews and did not feel unduly pressured by the targets.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy looks professional. It is tidy and organised. The signposting to the consultation room could be more prominent so it is clear to people that there is somewhere private for them to talk.

Inspector's evidence

The pharmacy was well laid out and presented a professional image. The dispensing benches were uncluttered and the floors were clear. The premises were clean and well maintained.

The consultation room was spacious but the signposting could be more prominent. The room contained a contained a computer, a sink and three chairs. There were two doors giving access to this room. Both contained clear glass panels which meant that patient confidentiality could not be maintained. The pharmacist gave assurances that these panels would be obscured. Conversations in the consultation room could not be overheard. The computer screens were not visible to customers. The telephone was cordless and all sensitive calls were taken in the consultation room or out of earshot.

The temperature in the pharmacy was below 25 degrees centigrade. There was good lighting throughout. Most items for sale were healthcare related.

Principle 4 - Services ✔ Standards met

Summary findings

People with a range of needs can access the services offered by the pharmacy, but some may need help entering the pharmacy.The pharmacy team make sure that people have the information that they need to use their medicines safely and effectively. They intervene if they are worried and escalate any concerns to their doctors. The pharmacy gets its medicines from appropriate resources. The medicines are stored and disposed of safely. The pharmacy team make sure that people only get medicines or devices that are safe.

Inspector's evidence

There was wheelchair access to the pharmacy and the consultation room but no bell on the door alerting staff to anyone who may need assistance. There was access to Google translate on the pharmacy computers for use by non-English speakers. The staff had used this recently for a Portuguese customer. The pharmacy could print large labels for sight-impaired patients and had done this in the past.

Advanced and enhanced NHS services offered by the pharmacy were medicine use reviews (MURs), the new medicine service (NMS), emergency hormonal contraception (EHC), supervised consumption of methadone and buprenorphine (currently 1 patient), needle exchange and seasonal 'flu vaccinations. The services were well displayed and the staff were aware of the services offered.

The pharmacist had completed suitable training for the provision of seasonal 'flu vaccinations including face to face training on injection technique, needle stick injuries and anaphylaxis. He had also completed suitable training for the provision of the free NHS EHC service.

Ninety domiciliary patients received their medicines in monitored dosage systems (MDS). The domiciliary dosettes were assembled on a small separate bench on a four-week rolling basis. They were evenly distributed throughout the week to manage the workload. All relevant information such as changes in dose were recorded on the patient's electronic prescription medication record. These were referred to at the checking stage. Most of the dosettes were checked by the ACT. There was an audit trail demonstrating that the prescriptions had been clinically checked prior to this. The pharmacy ordered the prescriptions on behalf of these patients and there was a good audit trail of what had been ordered. The assembled dosettes were stored tidily in a spacious upstairs area. There was more than sufficient room here for the trays to be assembled and checked in this area which would reduce the likelihood of distractions and errors. Procedures were in place to ensure that all MDS patients receiving high-risk drugs were having the required blood tests.

There was a good audit trail for all items ordered on behalf of patients by the pharmacy and for all items dispensed by the pharmacy. Interventions were seen to be recorded on the patient's prescription medication record. Green 'see the pharmacist' stickers were used such as one seen for naproxen. There was a dedicated laminated sheet identifying who should be counselled including patients prescribed high-risk drugs such as warfarin and lithium, antibiotics, new drugs and any changes. CDs and insulin were checked with the patient on hand-out. All the staff were aware of the new sodium valproate guidance. They currently had no female patients of child-bearing age prescribed this.

All prescriptions containing potential drug interactions, changes in dose or new drugs were highlighted to the pharmacist. Signatures were obtained indicating the safe delivery of all medicines and owing slips were used for any items owed to patients. The pharmacist reported that he frequently identified during MURs that people suffered from side effects due to medicines, such as, amlodipine and angiotensin-converting enzyme (ACE) inhibitors. He gave advice about this and escalated any concerns to their doctor.

Medicines and medical devices were obtained from AAH, Trident, OTC, DE, Lexon and Alliance Healthcare. The pharmacy had a scanner to check for falsified medicines but this was not yet operational. Some unlicensed medicines, such as cholecalciferol 800iu were seen on the dispensary shelves. Specials were obtained from Lexon Specials. Invoices for all these suppliers were available. CDs were stored tidily in accordance with the regulations and access to the cabinet was appropriate. There were no patient-returned CDs. Appropriate destruction kits were on the premises. Fridge lines were correctly stored with electronic records. Date checking procedures were in place with signatures recording who had undertaken the task. Doop bins were available for waste and used and there was a cytotoxic bin and a list of substances that should be treated as hazardous for waste purposes.

There was a procedure for dealing with concerns about medicines and medical devices. Drug alerts were received electronically, printed off and the stock checked. The alerts were stored in an electronic folder. Any alerts requiring action were kept in a folder. The actions were recorded.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the appropriate equipment and facilities for the services it provides.

Inspector's evidence

The pharmacy used British Standard crown-stamped conical measures (10 - 500ml). There were tablet-counting triangles, one of which was kept specifically for cytotoxic substances. These were cleaned with each use. There were up-to-date reference books, including the British National Formulary (BNF) 76 and the 2018/2019 Children's BNF. There was limited to the internet.

The fridges were in good working order and maximum/minimum temperatures were recorded daily. Doop bins were available and used and there was adequate storage for all other medicines.

The pharmacy computers were password protected and not visible to the public. There was a cordless telephone and any sensitive calls were taken in the consultation room or out of earshot. Confidential was information was shredded. The door was always closed when the consultation room was in use and no conversations could be overheard.

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.