General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Cornwells Chemists Ltd, 126 Wardles Lane, Great Wyrley, WALSALL, West Midlands, WS6 6DZ

Pharmacy reference: 1090294

Type of pharmacy: Community

Date of inspection: 20/05/2019

Pharmacy context

This is a community pharmacy located within a small shopping precinct with other local shops and services in Great Wyrley, South Staffordshire. People using the pharmacy are from the village and there is a limited home delivery service available. The pharmacy dispenses NHS prescriptions and provides some other NHS funded services. The pharmacy team provides medicines in weekly multi-compartment compliance aids for people that can sometimes forget to take their medicines.

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	Written procedures (SOP) are in place but staff do not always follow them and some members of staff have not read them.
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 not all met**

Summary findings

The pharmacy does not always identify and manage risk well. There are written instructions to help make sure its team work safely. But team members do not always follow them. This may increase the likelihood of things going wrong, or mean they miss learning opportunities. The pharmacy generally keeps all of the records it needs to by law. Team members do not fully understand their role in protecting vulnerable people. So, they may not be able to respond to concerns appropriately.

Inspector's evidence

The responsible pharmacist (RP) had been working at the pharmacy for 10 days and had moved from another branch of Cornwells Chemist. The previous pharmacy manager was leaving the company and the superintendent (SI) had identified that this branch required an experienced pharmacy manager rather than a locum pharmacist. The RP explained that he had been tasked with identifying areas for improvement and reporting back to the SI; he had already identified some areas for improvement. But, he was aware that there would be others.

A range of standard operating procedures (SOPs) were in available which covered most of the operational activities of the pharmacy and the services provided. SOPs had been prepared by the previous superintendent pharmacist (SI) in December 2017. Signature sheets were used to record staff training. But, most of the staff currently working at the pharmacy had not signed signature sheets to record their training. Roles and responsibilities of pharmacy staff were highlighted within the SOPs. There were some specific examples of when SOPs were not being followed in branch or did not reflect current practice. For example, the complaints SOP had not been followed when dealing with a dispensing error, and the SOP for dispensing weekly multi-compartment compliance aids did not reflect the 'hub and spoke' model.

The company operated a 'hub and spoke' model to dispense weekly multi-compartment compliance aids. Compliance aids were assembled using a 'robot' at the Newcastle-under-Lyme branch , which was the hub pharmacy. The hub and spoke branches carried out different parts of the dispensing process.

The pharmacy team could not locate the SOP or any other supporting documentation for the hub and spoke model, but a copy of the SOP was obtained from another branch during the inspection. This stipulated that the spoke pharmacy was responsible for clinically checking the prescriptions and inputting the information to the computer system, which was linked to the hub. This information was used by the hub to assemble the trays. The hub pharmacy was responsible for the final accuracy check, and then returned the dispensed trays to the pharmacy, to be supplied.

The pharmacist explained that he had asked the accuracy checking technicians (ACTs) in branch to perform an additional accuracy check of the trays when they were received in case any errors that had been made at the hub.
The additional accuracy check was not part of the SOP, so it could cause confusion about who is accountable in the event of an error reaching a member of public. The SOP for the hub operation was supplied after the inspection and contained a flow diagram to show the end to end process and which

members of staff were responsible for carrying out each process. The flow diagram was not included with the spoke SOP, so it was not clear to the team in the spoke branch which of their colleagues in the hub were accountable for the dispensing and accuracy checking stages.

Near miss logs were available and the dispenser involved was responsible for recording and correcting their own error to ensure they learnt from the mistake. A trainee dispensing assistant explained that each near miss was discussed at the time to see if there were any reasons for it, and it was used as a learning opportunity. Each dispenser recorded their own near misses on a personal log and these were kept in their individual working area. The dispensers explained that the previous pharmacy manager had asked for the logs just before he had left the branch, but they were unsure what he had used them for. The pharmacy team could not locate any records of near miss reviews or give any examples of when near miss patterns or trends had been used to make improvements. The number of near misses recorded on the individual logs for the trainee dispensers appeared to be low compared to the number of items dispensed and their personal experience of dispensing. This suggested that not all near misses were being recorded.

Dispensing incidents were recorded using an online form so that they were reported directly to the SI. An example of a previous dispensing error was available and a printed copy of the completed online form had been retained in branch. The SOP did not specify how errors identified in branch with the weekly trays should be reported to the hub.

Members of the pharmacy team were knowledgeable about their roles and discussed these during the inspection. The team spoke positively about the temporary pharmacy manager and how he had delegated more tasks to them. Pharmacy staff were wearing uniform and name badges with their job title on.

The complaints, comments and feedback process was explained in the practice leaflet and on a poster in the retail area. The RP had been asked to give feedback to the SI on customer service and had started by reviewing how quickly people were acknowledged when approaching the healthcare counter, how quickly the telephone was answered and stock holding.
Two part-time trainee medicine counter assistants had been recruited to support the shop supervisor. There was evidence that the complaints procedure had not been followed when a locum pharmacist had been made aware of a dispensing error and the staff that were present at that time did not follow the SOP for errors or complaints.

The pharmacy had up to date insurance arrangements in place.

The responsible pharmacist (RP) notice showed the correct details and was clearly displayed. There were occasional instances where the RP had not signed out and a different RP signed in the next day, so the log did not technically always comply with the law. CD registers were in order. A balance check for methadone was completed either weekly or two-weekly and the overage added into the running balance. There had been some mistakes in the running balance calculations which had been carried over and there had been some over-writing to correct them. Two random balance checks matched the balances recorded in the register. A patient returned CD register was in use.
Private prescriptions and emergency supplies were recorded in a record book. A sample of private prescription entries was seen to comply with legal requirements. But, for emergency supplies the reason for the supply was rarely recorded which is a legal requirement. Specials records were maintained with an audit trail from source to supply. NHS New Medicine Service (NMS) consent forms were seen to have been signed by the person receiving the service.

Completed prescriptions were stored out of public view. Confidential waste was stored separately and

sent offsite for destruction in special bags. Confidential information i.e. documents for pharmacy services were stored in areas which had restricted access although the door was accessible from the shop floor and was not locked. The RP could access NHS Summary Care Records (SCR) and confirmed that Smart card passwords were not shared.

The RP and pharmacy technicians had completed Centre for Pharmacy Postgraduate Education (CPPE) training on safeguarding. Details of local safeguarding contacts were available in the dispensary. A trainee dispensing assistant had basic knowledge of safeguarding concerns for children and gave examples of what she would refer to the RP but was unsure of signs of safeguarding concerns in vulnerable adults.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough staff to provide its services. Pharmacy team members complete the training they need to do their jobs. But they do not have formal training plans or protected time to complete ongoing training, so they may not always keep their skills and knowledge up to date.

Inspector's evidence

The pharmacy team comprised of three accuracy checking technicians (ACT), a supervisor (medicines counter assistant and trainee dispensing assistant), a dispensing assistant, a trainee dispensing assistant, two apprentices, two trainee medicine counter assistants and a delivery driver. Training certificates were displayed as evidence that accredited training courses had been completed.

One of the ACTs and the dispensing assistant were on maternity leave at the time of inspection and a member of staff from the shop had left the company. The pharmacy team explained that there had been several staffing changes in the past 12 months and this had included recruiting two apprentices and two trainee medicine counter assistants to replace staff that had left and to provide cover in the dispensary for staff that were on maternity leave.

The pharmacy manager was working his notice period and a temporary branch swap had taken place. The superintendent thought this branch was more in need of an experienced pharmacy manager to review and improve processes and procedures so that it was ready for a new pharmacy manager to take over. The team thought a new pharmacy manager had been recruited and was working his notice at his current workplace.

The temporary pharmacy manager had reviewed the contracted staffing hours against the current workload and felt that there were enough contracted hours within the branch. His initial observation was that the core rotas did not match the needs of the business and that the contingency plan for annual leave did not provide enough cover. He said that he would continue to review and report back to the superintendent. The company used external HR advisers who could support the pharmacy manager if required.
Annual leave was booked in advance and the ACT managed the holiday diary. One member of staff in the shop and one member of staff in the dispensary could take holiday at any one time.

Several members of staff were enrolled on accredited training courses or were within their 12-week induction period. An apprentice explained that she attended college every week and the trainee dispensing assistant said that she was enrolled on an accredited training course but was behind on her course work and required an extension. The trainee dispensing assistant did not receive any protected training time and her personal circumstances meant that completing course work at home was very difficult. Two trainee medicine counter assistants had been recruited and were part way through their 12-week induction period. Staff were unsure about the company appraisal process and a long-serving member of staff could not remember having an appraisal with the previous pharmacy manager.

Staff said that the previous pharmacy manager held one to one ‘counselling’ sessions with them and

they were told what they were doing incorrectly during this session. Staff said they thought that this was something that the previous pharmacy manager had decided to do and did not think it was the company appraisal process.

The team worked well together during the inspection and were observed helping each other and moving onto the healthcare counter when there was a queue. Pharmacy staff had regular discussions in the dispensary to communicate messages and updates. The pharmacy staff said that they could discuss any ideas, concerns or suggestions with the temporary pharmacy manager but said that they had been reluctant to speak to the previous manager. The team explained that the temporary pharmacy manager had already made several positive changes and was very open to suggestions or discussion. Staff said they would speak to the ACTs or pharmacy manager if they had any concerns and the contacts details for the superintendent were available if required.

The RP was observed making himself available to discuss queries with people and giving advice when he handed out prescriptions. Targets were in place for services; the RP explained that he would use his professional judgement to offer services e.g. MURs when he felt that they were appropriate.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean, secure and suitable for the services currently provided.

Inspector's evidence

The pharmacy was smart in appearance and appeared to be well maintained. Any maintenance issues were reported to head office. The dispensary was an adequate size for the services provided and an efficient workflow was seen to be in place. Dispensing and checking activities took place on separate areas of the worktops.

There was a private soundproof consultation room which was used by the pharmacist during the inspection. The consultation room was professional in appearance. The door to the consultation room remained closed when not in use.

The dispensary was generally clean and tidy with no slip or trip hazards evident. The pharmacy was cleaned by pharmacy staff. The sink in the dispensary had hot and cold running water, hand towels and hand soap available. The floor in the dispensary had a layer of dust that had gathered in the corners and along the edges and the sink would benefit from a deeper clean. Some carrier bags containing prescriptions were stored directly on the floor in the dispensary which was not ideal considering there was ample storage space available.

The pharmacy had air conditioning and the temperature in the dispensary felt comfortable during the inspection. Lighting was adequate for the services provided.

Prepared medicines were held securely within the dispensary and pharmacy medicines were stored behind the medicines counter. There was a pharmacy medicine on self-selection in the shop; this was an oversight by the staff member who put the delivery away, as they had forgotten the legal status of teething gels had changed, and the stock was removed from the shelves.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy gets its medicines from licensed suppliers. It takes the right action if medicines need to be returned to the supplier. But, the pharmacy does not always document expiry date checking or fridge temperature records, so, they it may not be able to provide assurance that all stock is fit for purpose. The pharmacy does not provide medicine leaflets with weekly multi-compartment compliance aids. This means that people do not have all the information they need to take their medicines.

Inspector's evidence

The pharmacy was situated within a small shopping precinct and there was a large, free car park for customers. There was a touch-pad assisted front door and step-free access.

A prescription collection service was in operation. The pharmacy had some audit trails in place for the prescription collection service, but they were not following the SOP as they were not recording the prescriptions that had been ordered or chasing missing items. The pharmacy offered different services dependent on what the person preferred, and the surgery allowed. A limited delivery service was available, on Fridays, for people that had no other way to obtain their prescriptions.

A range of health promotion leaflets and posters were available and pharmacy staff used local knowledge and the internet to support signposting.

Dispensing baskets were used to keep medication separate. Different coloured baskets were used to prioritise workload. A dispensing audit trail was in place through the practice of staff signing their initials on dispensed and checked by boxes on dispensing labels.

Medicines were dispensed in compliance aids for a large number of people, on a weekly or monthly basis. Approximately half of the compliance aids were assembled in branch and the rest were assembled at a hub.
The ACTs managed the administration process for the trays. Every person had their own file which contained a list of the medicines to be packed into the compliance aid, details of which slot they should be packed into and what external items the person required. Prescriptions were ordered in advance to allow for any missing items to be queried with the surgery ahead of time.

All of the weekly supplies and some of the monthly supplies were dispensed in branch. The team had decided to dispense the more complicated compliance aids or the pcompliance aids prone to last minute changes in branch as it was easier to control when they were dispensed. Compliance aids were dispensed by any member of the team using the patient file as a guide.

Prescriptions to be sent to the hub were ordered, put onto the computer and clinically checked in branch and then transmitted electronically to the hub for assembly. They were then assembled and accuracy checked at the hub before being returned to the branch. External items were dispensed in branch. The pharmacy was given a cut-off time to transmit their prescriptions to the hub by. This helped the hub manage their workload and ensure prescriptions were returned to the branch to coincide with

the delivery day.

Descriptions of medication were written onto the compliance aid inserts so that people could identify and differentiate between the medicines in the packs. Patient information leaflets were not routinely supplied with any compliance aids. This is a legal requirement and without the leaflets patients and carers may not have all of the information they need to use the medicines safely.

The original prescription for any items owing and an owing docket was kept until hand out to allow for any counselling to be given.

A range of stickers were available to highlight prescriptions that required additional counselling to be provided when they were handed out. This had been implemented by the temporary pharmacy manager. A medicine counter assistant knew that people prescribed warfarin should have a yellow book, but it was not routine practice to ask to see it in branch. The RP attached a 'see pharmacist' sticker to any prescriptions that contained valproate for people who may become pregnant, so he could personally counsel the patient and ensure they had a pregnancy prevention plan. The purple folder containing the supporting counselling materials could not be located during the inspection which meant they may not be able to supply all of the necessary information when valproate was dispensed.

Several expired prescriptions containing schedule 3 controlled drugs, exempt from safe custody requirements, were still in the collection area. A trained medicines counter assistant did not identify that they had expired and incorrectly thought they had a three month expiry date. This meant there was a risk that medicines could be unlawfully supplied after the prescriptions had expired.

No out of date medicines were seen during the inspection. Date checking records were not kept and therefore the SOP for date checking was not being followed . The SOP stated that the dispensary should be date checked every two months and there was no evidence of this occurring as the date checking record books were generally blank.
Medicines were obtained from a range of licenced wholesalers. Medicines were stored in an organised manner on the dispensary shelves. Medicines were stored in their original packaging. Split liquid medicines with limited stability once opened were marked with a date of opening.
The RP explained that the pharmacy was compliant with FMD legislation as they had barcode scanners, had registered with SecurMed and the system was working. The team were not observed routinely scanning FMD compliant barcodes during the inspection.

There were two medical fridges in the dispensary to hold stock medicines and assembled medicines. The medicines in the fridges were stored in an organised manner. Fridge temperature records were kept, and records showed that the pharmacy fridges were working within the required temperature range of 2 and 8 degrees Celsius. A third fridge was used specifically to store stock for a travel vaccination clinic, although this service was currently on hold and the RP thought the stock was due to be sent back to the supplier. Fridge temperature checks for this fridge had not been carried out since March so the pharmacy could not provide assurance that the medicines had been stored appropriately and were fit for purpose.

Patient returned medicines were stored separately from stock medicines in designated bins.

The pharmacy received drug alerts from head office. Each alert was printed and annotated to show it had been actioned and then stored in a drug recall folder.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has appropriate equipment and facilities to provide the services it offers.

Inspector's evidence

The pharmacy had a range of up-to-date reference sources and internet access was available. There was a blood glucose monitor and a blood pressure machine available for a free health check service. The RP was unsure of when either machine required re-calibration or replacement.

Patient records were stored electronically and there were enough terminals for the workload currently undertaken. A range of clean, crown stamped measures were available. Separate measures were available for the preparation of CDs Counting triangles were available. There was a separate, marked triangle used for cytotoxic medicines.

Patient medication records were stored electronically and access was password protected. Screens were not visible to the public as members of the public were excluded from the dispensary. Cordless telephones were in use and staff were observed taking phone calls in the back part of the dispensary to prevent people using the pharmacy from overhearing.

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.