General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Phoenix Pharmacy, Phoenix Health Centre, Parkfield Road, Parkfields, WOLVERHAMPTON, West Midlands, WV4 6ED

Pharmacy reference: 1092476

Type of pharmacy: Community

Date of inspection: 06/08/2024

Pharmacy context

This extended hour community pharmacy is located inside Phoenix health centre, Wolverhampton. It is open seven days per week. Its main activity is dispensing NHS prescriptions. It also provides some additional NHS services such as Pharmacy First, New Medicine Service and a supervised consumption medicine service. Some people are supplied their medicines in multi-compartment compliance packs to help take them correctly. A delivery service is available for people that cannot attend the pharmacy in person to obtain their medicine supplies.

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 written procedures to help make sure its team works safely. Its team members record their mistakes so they can learn from them. And they take some action to help reduce the chance of similar mistakes happening again. But they do not regularly review mistakes for common trends, so they may miss some opportunities to learn and improve. The pharmacy keeps the records it needs to by law. Pharmacy team members know how to keep people's private information safe. And they recognise and report concerns about vulnerable people to help keep them safe.

Inspector's evidence

The pharmacy had processes in place to identify and manage risk, including the recording of dispensing errors and near misses. Two of the dispensers explained that the pharmacist discussed near misses with them at the time they came to light. Action had been taken to reduce some risks that had been identified. For example, amitriptyline and amlodipine tablets had been distinctly separated on dispensary shelving following some near misses with these medicines. Team members also attached shelf edge labels near to medicines that were liable to picking errors due to their look alike sound alike properties. However, some stock had been moved so the labels weren't always in the correct place to be an effective prompt. Near misses were not reviewed so team members may not always identify common mistakes and emerging trends so that action can be taken to reduce the risk of similar mistakes from happening. Some records of dispensing errors were seen. The details of the error were included along with tangible actions that the pharmacy team had taken to learn from the adverse events. A complaints SOP was available, and the responsible pharmacist (RP) explained they would try to resolve complaints verbally. If this was not possible, they would then refer to head office and the superintendent pharmacist (SI). The complaints process was not advertised so people may not know the correct way to provide feedback.

A range of electronic standard operating procedures (SOPs) underpinned the services provided and these had been regularly reviewed. The SOPs had recently been amended following to reflect the updated guidance on the supply of valproate containing medicines and the introduction of NHS Pharmacy First service. Team members had read the SOPs but there was no evidence of this in the form of a training record. However, they were knowledgeable about their roles and responsibilities and were observed following the written processes. The pharmacy team correctly described the activities that could not take place if the RP was absent.

Evidence of current professional indemnity insurance was available. Records were properly maintained, including RP, private prescription, emergency supply, unlicensed specials, and electronic controlled drug (CD) records. Running balances for CDs were checked frequently. A few running balances were checked against the physical stock and found to be correct. Patient returned CDs were recorded in a book and signed when destroyed.

Pharmacy team members had signed confidentiality agreements when they were first employed, and information governance training was completed as part of the NHS Data Protection and Security annual submission. They were aware of the need to protect confidential information, for example by identifying confidential waste and disposing of it appropriately. The pharmacist had undertaken advanced formal safeguarding training. The team had access to guidance and local safeguarding contact

details. Team members were able to correctly explain the action they would take if they had any concerns.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy generally has enough staff to manage its workload effectively. Most pharmacy team members are appropriately trained for the jobs they do. But some team members are not enrolled on to a suitable training course in a timely manner. This may mean they do not have the correct skills or knowledge for their role. Team members feel comfortable speaking up about any concerns they have.

Inspector's evidence

The pharmacy team consisted of a regular RP, two dispensing assistants, a trainee foundation pharmacist, and a trainee medicines counter assistant. Locum pharmacists were also used to cover some of the opening hours. Some team members were unexpectedly absent during the inspection due to sickness. The RP had called head office for support and another colleague was due to join later in the afternoon. Two dispensing assistants who were not present had been working at the pharmacy for over a year, but they had not been enrolled on to an accredited dispensing course. This meant they may not have the correct skills and qualification for their role. The RP subsequently provided evidence of team members being enrolled on to a training course with a recognised provider. Pharmacy team members were observed prioritising the workload and helping each other to manage tasks safely and effectively. The RP was seen making themselves available to support with any queries.

A dispenser was able to provide an explanation of the questioning technique used when selling medicines to makes sure sales were appropriate and gave appropriate examples of situations, they would refer to the pharmacist. They also identified higher-risk pharmacy medicines and explained they took extra care when selling these. Multiple requests for medicines liable to abuse were referred to the RP. There was no formal performance and development process in place for team members, which meant some opportunities to identify training needs could be missed. However, pharmacy team members understood that they could discuss issues with the pharmacist informally whenever the need arose. And they felt comfortable raising concerns with the RP. There were no specific targets or incentives set for the services provided.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy has facilities so people who need to have a private conversation can do so, and the premises are maintained to an appropriate level. The premises are generally large enough to support the level of workload that the pharmacy processes. The pharmacy keeps its premises clean, but some areas of the dispensary are cluttered. This means its team members cannot make best use of the available space.

Inspector's evidence

The pharmacy was clean, and the retail area looked professional in appearance. However, some areas of the dispensary were cluttered and untidy. Medicine deliveries from wholesalers were stored on the floor but the team had tried to place them in a way to reduce the risk of them becoming a trip hazard. Due to unexpected staff absence, team members had slightly fallen behind on keeping the dispensary tidy. The RP explained they would make sure that any untidy areas are rectified immediately. The dispensary was of an adequate size and team members utilised the space well to help assemble prescriptions safely. Clear bench space was available for the pharmacist to complete the final accuracy check. The room temperature was maintained to a suitable level using fans and heaters. And lighting was adequate. A clean sink was available to help prepare medicines that required mixing before being supplied to people.

A small consultation room was available for people to receive a service or have a private conversation with a member of the team. It was large enough for the services that were being provided. It was also used for storage which detracted from a professional appearance. A computer system was available in the room to help the team record services that had been delivered. Team members used the WC facilities located in the health centre. A small staff area had been designated in the dispensary for refreshment breaks.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's services are easy for people to access. Its working practices are generally safe and effective. But members of the pharmacy team do not always know when some higher-risk prescription medicines are being handed out. So they might not always be able to check that medicines are still suitable, or give people advice about taking them. The pharmacy stores medicines appropriately and carries out some checks to make sure they are in good condition and suitable to supply.

Inspector's evidence

The pharmacy team provided a range of services, but these were not clearly advertised so people may not always know what is being offered. There was wheelchair access into the pharmacy and consultation rooms. The retail area had some chairs so that people could sit and wait whilst their prescriptions were being assembled. A medicine delivery service was available, and a record of deliveries was kept. But the date and time was omitted on some records which may make it harder for the pharmacy to respond to any queries following a delivery.

Dispensing baskets were used to ensure medicines did not get mixed up during the dispensing process and to differentiate between different types of prescriptions. Dispensing labels were initialled by the dispenser and accuracy checker to provide an audit trail. Medicines awaiting collection could be seen from the retail area, but patient identifiable information was protected. Controlled drugs requiring safe custody and fridge lines were marked with a sticker to act as a reminder to add these when people came to collect their medicines. And CDs that did not require safe custody storage had the date of expiration written on the prescription to avoid them being supplied past the legal 28-day limit. Owing notes were provided to people when the full amount of a medicine was not provided to serve as a reminder to collect them at a later date. Higher-risk medicines such as methotrexate and warfarin were not routinely highlighted so there was a risk that counselling opportunities could be missed. The pharmacy team were aware of the risks of using valproate-containing medicines during pregnancy. They were also aware of the requirement to supply valproate products in original packs. They confirmed that anyone prescribed valproate who met the risk criteria would be counselled and provided with educational information at each time of dispensing.

The pharmacy provided medicines in multi-compartment compliance packs to some people in the community. People requesting the service were risk-assessed for suitability. Most compliance packs were labelled with descriptions of the medicines they contained. However, some descriptions did not always include enough detail with some missing either the shape or colour. So, there was a risk that people might not always be able to identify the medicines within the pack. Patient information leaflets were said to be routinely supplied. But two packs that were checked did not have the leaflets enclosed so people may not always be able to access the most up to information about their medicines. Each patient had a clear plastic wallet that included their personal and medication details, collection or delivery arrangements and any relevant documents, such as repeat prescription order forms. Changes to medications or doses were also recorded.

The RP had completed both online and face to face training to develop their skills and

knowledge for the NHS Pharmacy First service. Uptake of the service was high as the pharmacy was

open extended hours and on the weekends which was when most of the referrals were received. Signed copies of the patient group directions (PGDs) were available and the RP had easy access to the clinical pathways' information for reference. The pharmacy also supplied a large number of people who use drugs with medicines to help them with their care. A supervised consumption service was available and a private, concealed area was used for people to discretely take their medicines.

Medicines were obtained from licensed wholesalers and were stored appropriately. Medicines requiring cold storage were kept in a large, well-organised medical fridge. However, some cold chain medicines awaiting collection were seen to be stored in a fridge used by team members to store refreshments and food. The temperature of the fridge was not appropriately monitored with some gaps in the record. The RP promptly removed the medicines and stored them in the medical fridge. They also verbally reinforced to team members the correct storage requirements. Maximum and minimum temperatures for the fridge was recorded daily and were seen to be within the required range. Controlled drugs were stored in three, well-organised CD cabinets and obsolete CDs were kept separately from usable stock.

There was some evidence to show that the expiry dates of medicine stock had been checked, although the frequency and scope of these checks were not documented. This created a risk that out-of-date medicines might be overlooked. And a couple of expired medicines were found. Short-dated items were said to be highlighted with a sticker, but a few medicine boxes were seen without one which increased the risk of them expiring and not being identified. The RP admitted they had fallen behind with date checking with the last recorded one being completed in July 2023. They provided an assurance that a full date check would be prioritised. Date-expired medicines were disposed of appropriately, as were patient returns, waste sharps and clinical waste. The pharmacy received safety alerts and recalls electronically. A record was maintained but it did not detail what action had been taken, if any. So it may make it harder for team members to demonstrate they steps they took following a recall.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy team has the equipment and facilities it needs to provide the services that the pharmacy offers. And it makes sure these are always safe and suitable for use. The pharmacy's team members use equipment and facilities in a way that protects people's privacy.

Inspector's evidence

The pharmacy used a range of validated measures to measure liquids. An automated measuring pump was used to dispense methadone. It was cleaned and calibrated daily with records available to show this had been completed. Triangles were used to count loose tablets, and a separate one was being used to count loose cytotoxics.

Team members used the internet to access reference resources when needed. All equipment was in good working order, clean and appropriately managed. Equipment and facilities were used in a way to protect the privacy and dignity of patients and the public. For example, the consultation rooms were used for private conversations and counselling. The pharmacy software system was protected with a password and computer screens were not visible to people using the pharmacy.

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.