General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Drake Pharmacy, 1A Aintree Road, BOOTLE, Merseyside, L20 9DL

Pharmacy reference: 1092775

Type of pharmacy: Community

Date of inspection: 20/05/2019

Pharmacy context

This is a community pharmacy next door to a medical centre. It is situated on a major road through Bootle, north of Liverpool. The pharmacy dispenses NHS prescriptions, private prescriptions and sells over the counter medicines. It also supplies smoking cessation items from vouchers written by local stop smoking services. A number of people receive their medicines inside multi-compartment compliance aids.

Overall inspection outcome

Standards not all met

Required Action: Improvement Action Plan

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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 not all met	2.2	Standard not met	Some of the staff have not been enrolled onto the training course appropriate for their role. So they do not meet the GPhC's policy on the minimum training requirements for pharmacy support staff.
3. Premises	Standards met	N/A	N/A	N/A
4. Services, including medicines management	Standards not all met	4.3	Standard not met	Medicines are stored inside unsealed multicompartment compliance aids for some time. This is a potential risk regarding the stability of these medicines. Medicines are not always stored in line with safe custody requirements.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance ✔ Standards met

Summary findings

The pharmacy team follows written procedures to help make sure it provides services safely and effectively. Members of the pharmacy team sometimes record things that go wrong. But they do not always try to learn from them, so they may miss opportunities to improve. The pharmacy keeps most of the records that are needed by law. But sometimes the records are incomplete, so the pharmacy may not be able to show what has happened if it needs to. Staff are given training about the safe handling and storage of data, so that they know how to keep private information safe.

Inspector's evidence

There was a current set of Standard Operating Procedures (SOPs) which were last issued in November 2017. The pharmacy team had signed to say they had read and accepted some of the SOPs, but they had not signed the SOPs related to the responsible pharmacist (RP). So they may not fully understand what can or cannot be done when the RP is not on the premises.

Dispensing errors were recorded by the superintendent pharmacist (SI) in a book. The last error was recorded in 2015 and the SI said he was not aware of any more recent errors. The SI said he would discuss errors with the pharmacy team.

A small number of near miss incidents had been recorded. The SI said he would discuss errors with individual staff and if it was a significant error, he would discuss it as part of a team meeting. But there was no formal review of the records to identify trends or underlying factors. The pharmacist could not provide any examples of action that had been taken to reduce future risk following an error.

Roles and responsibilities of the pharmacy team were described in individual SOPs. The dispenser was able to describe what her responsibilities were and was also clear about the tasks which could or could not be conducted during the absence of a pharmacist. Staff wore standard uniforms and had badges identifying their names and roles.

The pharmacy had a complaints procedure and it was described in the practice leaflet. It advised people how to make direct contact with the pharmacy team. Complaints were recorded on a standardised form for the SI to follow up.

A current certificate of professional indemnity insurance was on display in the pharmacy. Two pharmacists were working in the pharmacy. Both pharmacists had their RP notice displayed and they were both signed into the RP log for the day. There were numerous entries in the RP log in which two pharmacists had signed in at the same time without designating one as the RP. This does not meet current legal requirements, and the company may not be able to show who was responsible at a specific point in time.

Records for private prescriptions and emergency supplies were recorded electronically. However; there were numerous records where the emergency supply did not state the nature of the emergency. This is a legal requirement and if it is not recorded the pharmacy may not be able to demonstrate that the supply was appropriate.

Records of unlicensed specials did not contain the required details about who the supply was made to

and when. An information governance (IG) policy was available. The pharmacy team had read the policy and had signed confidentiality agreements. When questioned, the dispenser was able to correctly identify what information was considered confidential and how it was destroyed using the on-site shredder. Some information about how the pharmacy handled and stored patient data was available in a leaflet. The SI said he had a privacy notice available in a folder, but it was not on display.

Safeguarding procedures were included in the SOPs. They were also on display in the dispensary with the contact details of the local safeguarding board. The pharmacy team said they had read the safeguarding procedures and pharmacists said they had completed level 2 safeguarding training. The dispenser said she would initially report any concerns to the pharmacist on duty.

Principle 2 - Staffing **Standards not all met**

Summary findings

There are enough staff to manage the pharmacy's workload. But some of the staff have not been enrolled onto an appropriate training course. So they may not always have the skills and knowledge they need to work effectively.

Inspector's evidence

The pharmacy team included two pharmacists – one of whom was the SI, two dispensers and two medicine counter assistants (MCA). The SI said the two MCAs were involved in the receipt of prescriptions, handout and sales of medicines, and some dispensing. They commenced their roles over six months ago, but they had not been enrolled onto any training courses related to the sales of medicines or dispensing. This is not in line with the GPhC's minimum training policy for pharmacy support staff.

The normal staffing level was two pharmacists and three dispensary staff. The volume of work appeared to be managed. Staffing levels were maintained by part-time staff and a staggered holiday system. Staff had access to various learning booklets received through the post and some were enrolled onto modules such as dementia friends. The training topics appeared relevant to the services provided and those completing the learning. Certificates of training were kept, but training modules were not provided in a structured or consistent manner. Which may mean training needs are not always identified or addressed.

The dispenser gave examples of how she would sell a Pharmacy Only medicine using the WWHAM questioning technique, refuse co-codamol sales she felt were inappropriate and refer people to the pharmacist if needed.

The second pharmacist routinely worked alongside the SI. He said he felt able to exercise his professional judgement and this was respected by the SI and the pharmacy team. The dispenser said she received a good level of support from the pharmacists and felt able to ask for further help if she needed it. Formal appraisals were not provided to the pharmacy team, but the dispenser said she would receive on the job feedback from the SI. Staff were aware of the whistle blowing policy and staff said that they would be comfortable reporting any concerns to the SI. There were no targets set by the company.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are suitable for the services provided. A consultation room is available to allow private conversations.

Inspector's evidence

The pharmacy was clean and tidy, and appeared adequately maintained. The size of the dispensary was sufficient for the workload. A sink and washing facilities were available within the dispensary. Customers were not able to view any patient sensitive information due to the position of the dispensary and access was restricted by use of a gate.

The temperature was controlled in the pharmacy by the use of air conditioning units. Lighting was sufficient. The staff had access to a kettle, microwave, separate staff fridge, and WC facilities. A consultation room was available with access restricted by use of a lock. The space was clutter free with a desk, seating, and adequate lighting. The patient entrance to the consultation room was clearly signposted.

Principle 4 - Services **Standards not all met**

Summary findings

The pharmacy provides services that are easy to access. It manages its services to help make sure they are safe. But members of the pharmacy team do not always do all the checks they should when they hand medicines out. And they do not always give people all of the information they may need to use their medicines safely. The pharmacy obtains its medicines from appropriate sources. But it does not always store them appropriately to make sure they are secure and kept in good condition.

Inspector's evidence

Access to the pharmacy was via a ramp to a single door and was suitable for wheelchair users. The consultation room was wheelchair friendly and the PMR system was capable of producing large print font. Pharmacy practice leaflets gave information about the services offered. Pharmacy staff were able to list and explain the services provided by the pharmacy. If the pharmacy did not provide a particular service staff were able to refer patients using a signposting folder.

The pharmacy opening hours were displayed in the practice leaflet, and a range of leaflets provided information about various healthcare topics. There were local restrictions in the area which prevented the pharmacy from ordering prescriptions on behalf of people.

The pharmacy had a delivery service. Deliveries were segregated after their accuracy check and written onto a delivery sheet. Dispensed by and checked by boxes were initialled on dispensing labels to provide an audit trail. Dispensing baskets were used for segregating individual patients' prescriptions to avoid items being mixed up. Owing slips were in use to provide an audit trail if the full quantity could not be immediately supplied.

Dispensed medicines awaiting collection were segregated away from the dispensing area on a collection shelf using an alphabetical retrieval system. Prescription forms were not retained. So the pharmacy team may not have all of the information they may need when medicines are handed out. A note was written onto the bag label to identify when fridge or CD safe storage items needed to be added. Staff were seen to confirm the patient's name and address when medicines were handed out.

Schedule 3 and 4 CDs were not highlighted. So there is a risk that these medicines could be supplied after the prescription had expired. And because the prescription forms are not retained the pharmacist may not be able to endorse the date when schedule 3 CDs are supplied, which is a legal requirement.

High risk medicines (such as warfarin, lithium and methotrexate) were also not highlighted. So the pharmacy team may not be aware when they are being handed out in order to check that the supply is suitable for the patient.

The pharmacy team did not specifically show fridge items, such as insulin, to the patient upon handout. Adopting this practice would allow the patient to confirm that they had been correctly prescribed and dispensed. The staff were aware of the risks associated with the use of Valproate during pregnancy.

Educational material was available to hand out when the medicines were supplied. The pharmacist said he would speak to any patients who were at risk and make them aware of the pregnancy prevention programme. But there were no relevant patients.

Some medicines were dispensed in MDS compliance aids. A record sheet was kept for all MDS patients; containing details of current medication. Any medication changes were confirmed with the GP surgery before the record sheet was amended. Hospital discharge sheets were sought. MDS trays were normally assembled before the prescription was received, which may increase the risk of error. The trays were not sealed until the prescription had been obtained, which was sometimes several days later. This meant the medicines were often left exposed for a prolonged period, which may adversely affect their stability and could allow contamination.

Disposable equipment was used to provide the service, and the MDS packs were labelled with medication descriptions and a dispensing check audit trail. Patient information leaflets (PILs) were not routinely supplied, which does not meet legal requirements and means patients and carers may not always have all the information they need to use the medicines safely.

Medicines were obtained from licensed wholesalers, with unlicensed medicines sourced from a special's manufacturer. The pharmacy was not yet meeting the safety features of the falsified medicine directive (FMD), which is now a legal requirement. Equipment was installed, but the pharmacy team said they were experiencing problems with the barcoded medicines which prevented them from always carrying out the safety feature checks.

A dispenser said she would check the expiry dates of medicines when she could, and the SI said this was with an ambition to complete a full date check 3 times per year. But this was not formalised into a programme or recorded. So there is a risk some medicines may be overlooked. Short dated stock was written onto a sheet for it to be removed at the start of the month of expiry. Liquid medication did not always have the date of opening written on, such as Morphine Sulphate oral solution which expired 3 months after opening. So the pharmacy team may not be aware if the medicine remains suitable for dispensing.

There was a clean medicines fridge with a minimum and maximum thermometer. The minimum and maximum temperature was being recorded daily and records showed they had been within the required range for the last 3 months. Patient returned medication was disposed of in DOOP bins located away from the dispensary.

Drug alerts were received electronically by email. The SI said he would action them when they were received. But he did not keep a record about the action taken so was not able to demonstrate that all alerts had been dealt with appropriately.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy team has access to the equipment they need for the services they provide.

Inspector's evidence

The staff had access to the internet for general information. This included access to the BNF, BNFc and drug tariff resources. All electrical equipment appeared to be in working order. According to the stickers attached, all electrical equipment had been PAT tested in August 2018.

There was a selection of liquid measures with British Standard and Crown marks. Separate measures were designated and used for methadone. The pharmacy also had counting triangles for counting loose tablets, including an electronic tablet counter.

Computers were password protected and screens were positioned so that they weren't visible from the public areas of the pharmacy. A cordless phone was available in the pharmacy which allowed the staff to move to a private area if the phone call warranted privacy. The consultation room was used appropriately; patients were offered its use when requesting advice or when counselling was required.

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.