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: 17/12/2019

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. The pharmacy supplies medicines in multi-compartment compliance aids for some people to help them take the medicines at the right time.

Overall inspection outcome

✔ **Standards met**

Required Action: None

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 met	1.7	Good practice	Members of the team are given training so that they know how to keep private information safe.
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 team follows written procedures, and this helps to maintain the safety and effectiveness of the pharmacy's services. And members of the team are given training so that they know how to keep private information safe. The pharmacy generally keeps the records it needs to by law, but they may not always be accurate. They record things that go wrong and discuss them to help identify learning. But they cannot show what they have done to help them to improve, so learning opportunities may be missed.

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 the SOPs.

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. He said he would discuss any errors with the pharmacy team. Records of near miss incidents were kept. The SI explained that he would usually discuss individual incidents with the staff involved, and if needed he would discuss it as part of a team meeting. But there were no records of action that had been taken in response to near miss incidents. So there may be some missed learning opportunities.

Roles and responsibilities of the pharmacy team were described in individual SOPs. A trainee 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. The pharmacy had a complaints procedure and details about it were on display in the retail area. It advised people how to make direct contact with the pharmacy team. Any complaints were recorded on a standardised form for the SI to follow up. A current certificate of professional indemnity insurance was on display.

The responsible pharmacist (RP) was signed into the RP log. Only one pharmacist was working in the pharmacy, but two RP notices were on display. This may cause some confusion to the public about who the current RP is. Records for private prescriptions, emergency supplies and unlicensed specials appeared to be in order. Controlled drugs (CDs) registers were maintained with running balances recorded. These were usually checked each month, but this had not been done since September. Two balances were checked, but they did not match the amount of stock present. The pharmacist identified the reasons for the discrepancies and amended the records. Patient returned CDs were recorded in a separate register.

An information governance (IG) policy was available. The pharmacy team had in-house IG training and each member of the team had signed a confidentiality agreement. When questioned, a trainee dispenser correctly described how she would keep confidential information away from the counter. Confidential waste was segregated to be destroyed using the on-site shredder. A privacy notice was on display in the retail area, explaining about how the pharmacy handled people's data.

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

on duty.

Principle 2 - Staffing ✔ Standards met

Summary findings

There are enough staff to manage the pharmacy's workload and they are appropriately trained for the jobs they do. Members of the pharmacy team complete some additional training to help them keep their knowledge up to date.

Inspector's evidence

The pharmacy team included two pharmacists – one of whom was the SI, and four dispensers – two of whom were in training. The normal staffing level was one or 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.

Members of the pharmacy team completed some additional training, for example using training booklets received through the post or using online training packages 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 was not provided in a structured or consistent manner. So learning needs may not always be fully addressed.

A trainee 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 pharmacist said he felt able to exercise his professional judgement and this was respected by the pharmacy team. A trainee dispenser said she received a good level of support from the pharmacists and pharmacy team, and she felt able to ask for further help if she needed it. She said she received on the job feedback from the pharmacists. But there was no appraisal programme. So development needs may not always be identified. 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 for professional services set by the pharmacy.

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 and access to it was restricted by use of a gate. 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. 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, adequate lighting and a wash basin. The patient entrance to the consultation room was clearly signposted.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's services are easy to access. And it manages and provides them safely. It gets its medicines from recognised sources, stores them appropriately and carries out regular checks to help make sure that they are in good condition. But members of the pharmacy team do not always know what medicines they are handing out. So they might not always be able to check that the medicines are still suitable, or give people advice about taking them.

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. 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 on display, and a range of leaflets provided information about various healthcare topics.

The pharmacy had a delivery service. Deliveries were segregated after their accuracy check and a sheet was used to record successful deliveries. Unsuccessful deliveries would be returned to the pharmacy and a card posted through the letterbox indicating the pharmacy had attempted a delivery. Some deliveries were posted through the letterbox or given to a neighbour. The SI said this was only done with the patient’s consent and once a verbal risk assessment had been completed. He said details about this were recorded on the PMR, but they did not have a process to review the arrangements to make sure circumstances had not changed. So the pharmacy may not know whether the arrangements continue to remain suitable.

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 always 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.

The pharmacist said he would keep schedule 3 or 4 prescriptions aside with the prescription attached, so he could check the expiry date of the prescription when it was being collected. High-risk medicines (such as warfarin and lithium) were not always highlighted. So the pharmacy team may not always aware when they were being handed out in order to check that the supply was suitable for the patient. The pharmacy team were currently highlighting prescriptions for methotrexate in order to help with the current audit they are completing. The pharmacist said they would also counsel the patient about their latest warfarin blood test result. But this was not always recorded on the patient’s PMR. 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 to make sure they were aware about the pregnancy prevention programme, and this was recorded on the patient’s PMR.

Some medicines were dispensed in multi-compartment compliance aids. Before a person was started on a compliance aid the pharmacist would complete a verbal assessment about their suitability. But this was not recorded, which would be useful information in the event of a query or concern. A record sheet was kept for each patient, containing details of their current medication. Any medication changes were confirmed with the GP surgery before the record sheet was amended. Hospital discharge sheets were sought, and previous records were retained for future reference. Disposable equipment was used to provide the service, and the compliance aids were labelled with medication descriptions and a dispensing check audit trail. Patient information leaflets (PILs) were routinely supplied.

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 had yet to commence routine checks of medicines. The expiry dates of dispensary stock were checked at least every 3 months. A record of completed date checking was kept and indicated the pharmacy team were up-to-date with the process. Any short-dated stock was recorded for it to be removed at the start of the month of expiry. Liquid medication had the date of opening written on.

Controlled drugs were stored appropriately in the CD cabinet, with clear segregation between current stock, patient returns and out of date stock. CD denaturing kits were available for use. There was a clean medicines fridge with a 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 by email from the MHRA. Alerts were printed, action taken was written on, initialled and signed before being filed in a folder.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

Members of the pharmacy team have access to the equipment they need for the services they provide. And they maintain the equipment so that it is safe to use.

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. Equipment was kept clean.

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.