General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Hills Pharmacy, 15 Hill Top Road, OLDBURY, West Midlands, B68 9DU

Pharmacy reference: 1093041

Type of pharmacy: Community

Date of inspection: 04/04/2023

Pharmacy context

This community pharmacy is located next to a medical centre in a residential area of Oldbury, West Midlands. It is open extended hours over seven days and most people who use the pharmacy are from the local area. The pharmacy dispenses NHS prescriptions, private prescriptions and it sells over-the-counter medicines. It offers a home delivery service, and it supplies medicines in multi-compartment compliance aids for some people to help them take their medicines at the right time. The pharmacy also provides a substance misuse service.

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 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 not all met	4.3	Standard not met	Some medicines present in the dispensary had been repackaged and were not appropriately labelled. And some had passed their expiry dates. This means the pharmacy cannot provide assurance that all its medicines are in good condition or safe to use.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance ✔ Standards met

Summary findings

The pharmacy manages risks adequately. But some of its procedures contain outdated information, so team members may not always have access to the most up to date information they need. The pharmacy keeps the records it needs to by law, but records are sometimes inaccurate, so team members may not always be able to show what has happened. Pharmacy team members understand how to keep people's private information safe and how to raise concerns to protect the wellbeing of vulnerable people. But the team does not consistently record or review its mistakes, so team members are missing out on learning opportunities.

Inspector's evidence

The pharmacy had a set of standard operating procedures (SOPs) covering the services it provided. The procedures stated that a review had taken place in 2020 but some information within the procedures was inaccurate or outdated. For example, an SOP which covered the dispensing of controlled drugs stated that electronic signatures were not permitted, and another stated the use of standardised CD requisition forms was best practice, rather than a legal requirement. Accompanying guidance documents were also out of date and included references to bodies such as the Royal Pharmaceutical Society of Great Britain (RPSGB) which ceased to exist in 2010. Pharmacy team members explained that they had read the procedures, but their signatures were often missing from the acknowledgment sheets at the end of each procedure. Through discussion, team members demonstrated an understanding of their roles, and a team member clearly explained the activities that could not take place in the absence of a responsible pharmacist (RP). The pharmacy had professional indemnity insurance in place and a certificate valid until June 2023 was provided by the superintendent pharmacist.

The pharmacy had a near miss log available. The log was dated January 2023, no entries had been recorded and previous records could also not be produced. Team members explained that entries were usually made by the pharmacist, after the near miss had been discussed with them. The team were unaware of any near miss reviews to identify underlying patterns or trends and near misses were not usually discussed in a team setting. The RP explained the actions that he would take in response to a dispensing incident. This included making an apology to the patient and an investigation to identify what had gone wrong. The RP was unsure of where incident report forms were in the pharmacy, but he explained that he would contact the superintendent pharmacist to identify where a record should be made.

People using pharmacy services provided verbal feedback to the team. A pharmacy team member explained that the consultation room could be used if people wanted to raise an issue in private and she explained that the team reflected on any negative issues raised to identify if changes could be made. The pharmacy had previously issued feedback questionnaire and comments could also be left online.

Upon the inspector's arrival the incorrect RP notice was displayed, this was swiftly rectified by the

pharmacist. The RP log was generally in order. But there were very occasional entries where the times the morning RP signed out and the afternoon RP signed in overlapped which may create some ambiguity as to who the RP was at a point in time. Private prescription records were also sometimes unclear. Electronic entries made through the patient medication record system sometimes recorded the incorrect prescriber details. There was also some confusion with a second private prescription register which recorded entries on paper. The use of two separate records made it difficult to reconcile some private prescriptions. Records for unlicensed specials were in order. Controlled drug (CD) registers kept running balances, but some record keeping issues were identified.

Pharmacy team members had a general understanding of data protection and confidentiality. A team member explained how people's private information was kept safe and confidential waste was shredded on the premises. Computer screens were not visible from the public area and team members held their own NHS Smartcards.

Team members explained the types of behaviours which they might find concerning. And the pharmacy had internet access to locate the contact details of local safeguarding agencies. The pharmacy had a chaperone policy which was displayed at the entrance to the consultation room.

Principle 2 - Staffing ✔ Standards met

Summary findings

Pharmacy team members are suitably trained for the jobs that they do, and they feel comfortable to raise concerns and provide feedback. But ongoing learning and development is limited. So, the pharmacy may not always be able to demonstrate how team members keep their knowledge and skills up to date.

Inspector's evidence

The pharmacy team consisted of the RP, who was a locum pharmacist and two dispensers. Two further dispensers arrived during the inspection. This was the usual staffing profile, and the dispensing workload was generally manageable. However, there had been some recent instability within the pharmacy, who had been operating with locum pharmacist cover for a number of months. A manager had been recruited at the end of 2022 but had recently left as had another team member. This had created a more pressurised environment and team members had fallen behind on some less urgent house-keeping tasks.

Pharmacy team members had completed suitable training for the roles in which they were working. But there was little ongoing training and team members did not receive any regular feedback on their development to help them learn and improve. Team members were reliant on the pharmacist for any updates they should be aware of, but there was a lack of consistency with no permanent manager. For example, a team member had learned of a recent medicines recall for pholcodine from the news, rather than in the pharmacy.

A dispenser discussed the sale of medication within the pharmacy. She clearly identified several higher risk medicines which may be susceptible to abuse and misuse and she explained the action that she would take in the event of any concerns, such as frequent requests to purchase. Queries such as medicines interactions were referred to the pharmacist and examples of this were witnessed during the inspection.

Pharmacy team members worked well together and there was an open culture. The team had a WhatsApp group which enabled them to have regular communication with the owner and superintendent pharmacist. They felt comfortable to raise concerns and provide feedback.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean and generally suitably maintained, but it is cluttered in places and some of the interior fixtures and fittings are dated, which detracts from the overall professional appearance. It has a consultation room to allow people to speak to team members in private.

Inspector's evidence

The pharmacy had a retail space with a small seating area for use by people waiting for prescriptions. The stock sold was suitable for a healthcare-based business and pharmacy only medicines were restricted from self-selection. The dispensary was compact, but separate areas were maintained for dispensing and checking. Although in a suitable state of repair, some of the interior fixtures and fittings within the pharmacy appeared dated, and several large tote boxes on the floor made the space appear cluttered. This detracted from the overall professional appearance. The lighting and ambient temperature were both appropriate. Team members had access to a staff WC and handwashing facilities.

The pharmacy had a small consultation room, which was signposted from the retail area. The room had a desk and seating to allow for private conversations, but there were some items being stored in the room, which appeared untidy.

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

Summary findings

The pharmacy sources its medicines from reputable suppliers, but it cannot always demonstrate that it stores them securely or that it manages them appropriately, so they are safe to use. The pharmacy's services are readily accessible, and it generally supplies medicines safely. But it does not always identify people on high-risk medications so opportunities to provide further counselling may be missed.

Inspector's evidence

The pharmacy had step free access from the car park. The manual door was visible from the medicine counter so people who needed help could be identified. There were some leaflets in the retail area which promoted health and there was some advertisement of pharmacy services.

Prescriptions were dispensed using baskets in order to keep them separate and help prevent medicines from being mixed up. Pharmacy team members signed dispensed by and checked by boxes so that those involved in dispensing processes could be identified. The pharmacy did not routinely identify prescriptions for high-risk medicines, so people may not get all the information or monitoring they need about their medicines. The pharmacist explained the actions he would take in response to a prescription for a valproate-based medicine for a person who may become pregnant. The pharmacy had some of the necessary education and warning literature available and team members said that further copies could be downloaded from the internet. The pharmacy did not highlight prescriptions for controlled drugs which were not subject to safe custody requirements, which could increase the risk that a prescription could be supplied after it had expired.

The pharmacy kept audit trails of repeat prescriptions requested from the GP surgery, so that unreturned requests could be identified and followed-up. Prescriptions for people who received their medicines in compliance aid packs were ordered automatically by pharmacy team member, who kept an audit trail to record when packs were assembled and checked. Completed compliance aid packs seen had a patient identifying label to the front, but there was not always a complete audit trail to identify those involved in the dispensing process. Descriptions of individual medicines were provided but patient leaflets were not always supplied in line with requirements.

The pharmacy sourced its medicines from a range of reputable suppliers and unlicensed medicines from a specials manufacturer. Stock medicines were stored in a generally organised manner, but there were a small number of shelves where medicines used for compliance aid dispensing were stored. These medicines were disorganised and were not being stored in the original packaging provided by the manufacturer. Several were being stored in medicines bottles which did not state the batch number or expiry date and others were loose tablets in the cardboard box. Pharmacy team members completed some date checking, but thy were behind on some checks and a few out-of-date medicines were identified during random checks of the dispensary shelves and the retail area. These were removed and placed in medicines waste bins.

The pharmacy had three CD cabinets which were suitably secured. The pharmacy fridge was fitted with

a maximum and minimum thermometer. The fridge was within the recommended temperature range, but the temperature record contained multiple gaps, so the pharmacy may not always be able to demonstrate the medicines are suitably stored.

Pharmacy team members explained that alerts for the recall of faulty medicines and medical devices were received from wholesalers. They believed that the superintendent pharmacist received alerts via email, but they did not receive these alerts through the pharmacy email and no audit trail was kept demonstrating the action taken in response to any alerts which were received.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities needed to deliver its services. And team members use the equipment in a way that protects people's privacy.

Inspector's evidence

The pharmacy had access to electronic resources including the British National Formulary and general internet access was available for further research. There were several glass Crown stamped and British Standard marked liquid measures, and separate measures were marked for use with CDs. Counting triangles for tablets were also available and the equipment seen was clean and suitably maintained.

Electronic equipment appeared to be in working order and some recent PAT test stickers were seen. Computer systems were password protected and screens faced away from public view. The pharmacy had cordless telephones, so conversations could take place in private, as 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.