General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Manor Pharmacy, 59 Forrester Street, WALSALL, West Midlands, WS2 9PL

Pharmacy reference: 1099353

Type of pharmacy: Community

Date of inspection: 03/03/2020

Pharmacy context

This community pharmacy is situated in a residential area of Walsall. It has a GP surgery and a local hospital nearby, and it is open 100 hours a week. The pharmacy dispenses prescriptions and sells a range of over-the-counter (OTC) medicines. It supplies some medicines in multi-compartment compliance aid packs to help make sure people take them at the correct time. It offers additional services including Medicines Use Reviews (MURs) and a local minor ailment scheme. A substance misuse treatment service is also available.

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 suitably identifies and manages the risks associated with its services. It maintains the records it needs to by law and keeps people's private information safe. Its team members are clear about their roles and responsibilities and they record their mistakes to help them learn and improve. Pharmacy team members understand how to raise concerns to help protect the wellbeing of vulnerable people.

Inspector's evidence

The pharmacy had standard operating procedures (SOPs) covering operational tasks and activities. The procedures had been reviewed by the pharmacist in February 2019, but some of the procedures contained information that was outdated and may no longer be relevant, such as expired website links and out-of-date contact details. Pharmacy team members had signed to confirm their acknowledgement of the procedures several years ago, but there was no audit trail confirming that they had read the procedures following the most recent review. A dispenser said that the team were informed verbally of any changes and updates to the procedures. She confirmed that she had read them more recently than the audit trail suggested. The team were clear on their roles and responsibilities and a dispenser accurately described the activities which were permissible in the absence of a responsible pharmacist (RP). The pharmacy had professional indemnity insurance provided by the National Pharmacy Association (NPA) which was valid until the end of May 2020.

The pharmacist recorded the details of any near misses. A dispenser discussed a recent near miss that she had been involved with, this had been discussed between her and the pharmacist and documented on the near miss log. The regular pharmacist signed to confirm a review of the log at the end of each month. A dispenser was not aware of any incidents where the same near miss had happened more than once. The pharmacist said that he had not identified any trends but that he had reviewed the dispensary shelves to try and make sure that common 'look alike, sound alike' medicines were clearly segregated, following some recent training. The pharmacist explained how dispensing incidents were recorded and copies of previous incident reports were filed for reference and had been onward reported to the National Reporting and Learning System (NRLS). The team were not aware of any recent incidents.

The pharmacy had a complaint procedure, which was advertised in the retail area. The pharmacy also participated in an annual Community Pharmacy Patient Questionnaire (CPPQ). Feedback from the most recent questionnaire was not seen, but the pharmacist reported that it was usually positive.

The correct RP notice was displayed near to the medicine counter. The RP log was maintained, but there was a missing entry for the morning of 13 January 2020, so it was not fully compliant. Records for private prescriptions did not always record the details of the prescriber, as per requirements. Emergency supply records were in order and records for the procurement of specials provided and audit trail from source to supply. Controlled drug (CD) registers kept a running balance and regular checks were usually completed. A patient returns CD destruction register was available and previous

entries had been signed and witnessed.

The pharmacy had some information governance procedures. It was registered with the Information Commissioner's Office (ICO) and its privacy notice was displayed. A dispenser discussed some of the ways in which people's private information was kept secure, confidential waste was segregated and shredded, and other confidential materials were suitably stored. Most team members had their own NHS smartcards. A dispenser was in the process of arranging to get her card unlocked. On the day, the smartcard of a dispenser who was not present was in the dispensing terminal, which demonstrated that cards are not always suitably secured when not in use.

The pharmacist had completed safeguarding training and the team discussed how a recent incident involving a vulnerable patient had been managed and escalated to the local mental health trust. A record of this had not been kept and this was discussed with the team, who agreed to record such interventions moving forward. A poster was displayed which provided a website address to access the most up to date safeguarding contact details.

Principle 2 - Staffing ✔ Standards met

Summary findings

Pharmacy team members work in an open culture and they hold the appropriate qualifications for their roles. Team members get some feedback on their development, but they have limited access to ongoing learning, which may restrict the ability for some individuals to remain fully up to date.

Inspector's evidence

On the day of the inspection, the regular pharmacist was working alongside two trained dispensers. The regular pharmacist, who was also the superintendent pharmacist worked during the core business hours and regular locum pharmacists covered evening shifts and most weekends. The pharmacy also employed another trained dispenser, who usually worked evenings and weekends. The pharmacy team members managed the current dispensing workload adequately and there was no backlog in dispensing. Planned leave was authorised by the pharmacist and cover was arranged amongst the team to try and ensure a suitable level of staffing was maintained. Cover for unplanned leave could be more difficult to arrange and the team would sometimes work with a member of staff down. A dispenser said that the dispensing workload was usually still manageable, but some non-urgent tasks could be more difficult to complete.

A dispenser discussed the sale of medication in the pharmacy. She clearly explained the questions that she would ask to help make sure sales were safe and appropriate and also discussed some of the types of concerns that might be referred to the pharmacist. Frequent requests for medicines such as co-codamol would be escalated, but the dispenser was unaware of any recent concerns of this nature.

Pharmacy team members held the appropriate qualifications for their roles, and their training certificates were clearly displayed near to the medicine counter. One dispenser said that they would read through information materials received through the post, or use online materials to keep up to date, this was usually done during quieter periods, such as weekends. An example of a recent topic covered was sepsis. Another dispenser had not completed any recent training and the team were not provided with protected training time. The pharmacist provided the team with updates and reviewed their development through informal discussions on an ongoing basis.

The team were comfortable providing feedback and they could raise concerns to the superintendent pharmacist or owner. They held open conversations with each other and worked well together as a team. A whistleblowing policy was in the SOP folder, and the pharmacist agreed to review the details to ensure that they were up to date. The pharmacist confirmed that there were no set targets in place for professional services.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is suitably maintained and secure. It has a consultation room which enables members of the public to access an area for private and confidential discussions.

Inspector's evidence

The pharmacy was suitably maintained, but the premises were quite old and there were some interior fixtures and fittings which were worn and may detract from the overall appearance. Maintenance concerns were escalated to the pharmacy owner, who arranged for any necessary repair work to be completed, by liaising with the building landlord. A previous issue with the consultation room had been resolved to a satisfactory standard. The premises were otherwise generally clean and tidy, and these duties were managed by the pharmacy team. There was adequate lighting throughout the premises and the temperature was suitable for the storage of medicines.

The retail area had a clear floor space and chairs were available for use by people waiting for their medicines. Near to the seating area was some health promotion literature and additional displays were also on the pharmacy windows. There was a small range of stock which was in keeping with a healthcare-based business and pharmacy restricted medicines were secured from self-selection behind the medicine counter.

The consultation room was accessed from behind the medicine counter. Prescription retrieval shelves were covered to help prevent patient identifiable data from being seen by people walking through. The room was fitted with a desk and seating and a notice was displayed to make people aware of its availability.

The dispensary had adequate space for the current dispensing workload. A dispensing terminal was fitted behind the medicine counter and the bench was divided in half to segregate dispensing and checking. Further dispensing space was available to the rear of the premises and large shelving units were fitted for the storage of medicines. There were a small number of tote boxes being stored on the floor, which may cause a trip hazard for pharmacy team members.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's services are generally accessible and suitably managed so that people receive appropriate care. The pharmacy sources and stores its medicines appropriately. Its team members carry out some checks to show that medicines are fit for supply.

Inspector's evidence

The pharmacy had a single step entry from the main street. A portable ramp facility was not available, which might restrict access for some individuals. The patient medication record (PMR) system could produce large print labels to assist people with visual impairment. And pharmacy team members were dual-lingual and regularly used their skills to provide counselling and resolve queries.

There was limited advertisement of the pharmacy's services and a practice leaflet was not available. The pharmacy had some health promotion literature available near to the seating area and team members could access materials to support signposting. A dispenser demonstrated an awareness of where the nearest travel vaccination service was located. Records of signposting were not routinely kept.

Prescriptions were dispensed using baskets, to keep them separate and reduce the risk of medicines being mixed up. An audit trail for dispensing was kept by signing dispensing labels. The pharmacy used stickers to help identify prescriptions for high-risk medicines and an example was seen where recent INR readings had been recorded for a patient regularly prescribed warfarin. The pharmacy had recently completed an audit of the use of valproate-based medicines in people who may become pregnant, and the pharmacist had contacted two patients who fell within the 'at-risk' criteria. The pharmacy had the necessary safety literature to supply with valproate products. Stickers were also used to identify prescriptions for CDs, to help make sure supplies were made within the valid 28-day expiry date.

Medications for people using multi-compartment compliance aid packs were ordered by members of the pharmacy team. Master record sheet was used to track all requests sent to the GP surgery and identify prescription discrepancies. Record sheets were updated when there were any confirmed changes to medicines. The pharmacy had one patient who received a valproate-based medicine in a compliance aid pack. The dispenser was unsure of how the risks around this were managed but said that stability had been discussed with one of the locum pharmacists. He agreed to review this with the regular pharmacist to help make sure that medicines which might be unsuitable for compliance aid packs were suitably identified. Completed packs had an audit trail for dispensing and descriptions of individual medicines were recorded. Patient leaflets were not always routinely supplied. So, some people may not have access to all the information they need about their medicines. Signatures were obtained to confirm the delivery of medicines. A card was left for any person who was not in at the time of delivery and medicines were returned to the pharmacy.

The pharmacy provided a local minor ailments service. The pharmacist was aware of restrictions which were in place on the number of times the service could be used during a set period of time. And team

members had access to the service specification and formulary, so they were clear on what could be supplied.

Medicines were sourced from licensed wholesalers and specials from a licensed manufacturer. Stock medications were stored in the original packaging provided by the manufacturer and they were organised on large shelving units throughout the dispensary. The pharmacist discussed date checking procedures, but records were not kept up to date. A small number of expired medicines were identified during random checks of the dispensary shelves, which indicated that date checks may not be systematic and could the risk of an expired medicine being supplied in error. The medicines were immediately removed from the shelves and placed for disposal. The pharmacy had several medicines waste bins available for obsolete medicines. The pharmacy was not yet fully compliant with the requirements of the European Falsified Medicines Directive (FMD). They had made enquiries with a software supplier but did not currently have the required hardware available to enable decommissioning checks. Alerts for the recall of faulty medicines and medical devices were received electronically and the pharmacist kept an audit trail of relevant alerts, which were signed to confirm they had been actioned.

CDs were stored appropriately, and expired CDs were segregated from stock. Random balance checks were found to be correct and CD denaturing kits were available. The pharmacy fridge was fitted with a maximum and minimum thermometer and was within the recommended temperature range. There were occasional gaps in fridge temperature records and the pharmacist agreed to review this moving forward.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide its services and equipment is generally used in a manner that protects people's privacy.

Inspector's evidence

The pharmacy team members had access to reference materials including a British National Formulary (BNF) and internet access to support further research. Some ISO approved glass measuring cylinders were available for measuring liquids and a separate measure was marked for use with CDs. The counting triangles were clean and suitably maintained.

Electrical equipment was in working order and had been recently PAT tested. Issues were usually resolved by the pharmacist or escalated to the pharmacy owner. Computer systems were out of direct public view and a cordless phone was available to enable conversations to take place in private. But the proximity of the dispensing terminal to the medicine counter may at times mean that some conversations could be overhead if there were people in the waiting area. The waiting area was usually quiet.

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.