General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: 7-11 Pharmacy, 84B Berners Street, LEICESTER, Leicestershire, LE2 0FS

Pharmacy reference: 1100687

Type of pharmacy: Community

Date of inspection: 22/08/2019

Pharmacy context

This community pharmacy is situated on a road with mixed housing and shops in Leicester. Most of the activity is dispensing NHS prescriptions and giving advice about medicines over the counter. The pharmacy supplies medicines in multi-compartment compliance packs to people who live in their own homes. It also supplies medicines to some people living in residential care homes. Other services that the pharmacy provides includes prescription deliveries to people's homes, Medicines Use Reviews (MUR), New Medicine Service (NMS) checks, and seasonal flu vaccinations under both NHS and private patient group directions (PGDs). The pharmacy also provides some medicines through private PGDs including malaria and meningitis prophylaxis.

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	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 mainly identifies and manages the risks associated with the provision of its services. The pharmacy adequately manages people's personal information. It knows how to protect vulnerable people. The pharmacy has some procedures to learn from its mistakes. But it doesn't record all its near misses. So, it could be missing opportunities to improve its services.

Inspector's evidence

The responsible pharmacist (RP) notice showing the name and registration number of the pharmacist in charge of the pharmacy was displayed. Underneath the notice there was a second notice showing the details of another pharmacist which might cause confusion. The pharmacist said he had thought that the second notice wasn't visible from the counter, so he removed it.

The pharmacy had a set of up-to-date standard operating procedures (SOPs). Each SOP listed the members of staff responsible for each activity. Not all staff had read the SOPs which might mean they didn't always follow pharmacy procedures.

The counter assistant had a good understanding of the questions to ask to sell a medicine safely. She had good product knowledge. She knew that prescriptions had a six-month validity and was aware that controlled drugs (CDs) could only be supplied within 28 days from the date on the prescription. She was aware of the CDs that were not stored in the CD cupboard and said that these were highlighted to remind the member of staff who was handing them out. Dispensed medicines waiting collection were kept on shelves. The prescription that related to the medicines was kept in a separate box. But, when the box was checked instead of the actual prescription sometimes there was a blank piece of paper with a bag label attached with a person's name and address. This meant that for those people the pharmacist would have to open the bag or check the person's electronic patient medication record to see the medicines that were being supplied. The pharmacist said this occurred when a medicine that had been sent out for delivery came back to the pharmacy. He said that he would remind the team of the need to put the prescription in the box.

An audit trail was created through the use of dispensed by and checked by boxes on the medicine label. The final check was by the RP. The pharmacy kept records of near misses, errors and incidents. The near misses were discussed with the member of staff at the time and with the team if it was a serious error or had occurred on a number of occasions. Records seen had only a small number of near misses up to August when the new pre-registration trainees had started. No near misses had been recorded for July. The pharmacist said that there might have been some near misses that had not been recorded but that the pharmacy had re-focused on recording near misses now the pre-registration trainees had started. The pharmacist said that the superintendent reviewed the log at the end of the month for trends and patterns, but he couldn't find any recent records. There was a notice on the wall highlighting some look-alike, sound-alike (LASA) medicines. The dispenser could explain the risks around LASA medicines and said that she had separated prednisolone and prochlorperazine.

Records to support the safe and effective delivery of pharmacy services were legally compliant. These included the RP log, private prescription records and the CD register. The CD register was audited regularly. There was a patient-returned CD register. A random check of the recorded running balance

of a CD reconciled with the actual stock in the CD cabinet.

The pharmacy provided a free blood pressure monitoring service and a diabetes testing service. There was a SOP and guidance information for both services. The pharmacy had up-to-date patient group directions (PGDs) for malaria and meningitis; the pharmacist's training certificates were available.

There was a complaints procedure in place. Staff would refer to the pharmacist if necessary. The results of the customer satisfaction survey for 2018/19 was on NHS.UK. Of the people who had completed the survey 99% were satisfied with the service provided. Public liability and professional indemnity insurance were in place until November 2020.

Computer terminals were positioned so that they couldn't be seen by people visiting the pharmacy. Access to the electronic patient medication record (PMR) was password protected. Confidential paper work was stored securely. Confidential waste was shredded. The pharmacy had an information governance protocol. The pharmacist was aware of safeguarding requirements; there was guidance which had been read by staff with local contact details available for reporting concerns.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy's team members are suitably trained for the roles they undertake. Team members work well together. They are able to share ideas to improve how the pharmacy operates. And they can raise concerns if needed. The team members receive support in keeping their skills and knowledge up to date. But a structured programme for on-going training could enhance the training provided.

Inspector's evidence

The pharmacy displayed who the RP in charge of the pharmacy was. The RP record showed who the RP in charge of the pharmacy had been.

During the inspection the pharmacy team managed the workload effectively. There was a pharmacist and two pharmacy pre-registration trainees who had only recently started at the pharmacy. There were three trained dispensing assistants, one of whom had just started pharmacy technician training. There was an apprentice counter assistant and a pharmacy undergraduate.

A member of staff said that they had annual formal appraisals. There was also the opportunity to provide informal feedback and give suggestions about how to improve the service. There was a whistleblowing procedure in place. Staff in-training said they felt supported in their development.

The pharmacist said that on-going training for staff was carried out on an in-house basis. He said that training was informal and a little ad-hoc; sometimes staff came into the pharmacy for training. Recent training had included the changes in medicine legislation. The pharmacist said that any targets didn't compromise customer service or his professional integrity.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy keeps its premises safe, secure and appropriately maintained. The pharmacy protects personal information.

Inspector's evidence

The pharmacy was clean and maintained to a suitable standard throughout. The public area and pharmacy facia presented a modern image. There was suitable seating for people waiting.

The dispensary was a suitable size for the services provided, with an adequate dispensing bench available for assembling prescriptions and reasonable space for storing medicines. The dispensary was clean and tidy; there was a sink with hot and cold water. The pharmacy was using a separate room upstairs for dispensing medicines for care homes and this was also suitable.

The pharmacy was an appropriate temperature for storing medicines; lighting was sufficient. A small size sound-proofed secure consultation room was available to ensure people could have confidential conversations with pharmacy staff. The room was used during the inspection. Computer screens were set back from and faced away from the counter. Access to the PMR was password protected. Unauthorised access to the pharmacy was prevented during working hours and when closed.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy mainly provides its services safely. The pharmacist is helpful and supportive to people who use the pharmacy. The pharmacy gets its medicines and medical devices from reputable sources. It mainly stores them safely but because not all medicines are stored in original packs it could mean that the pharmacy isn't always able to identify all expired stock or stock affected by drug recalls.

Inspector's evidence

The pharmacy was in a mixed street of residential and shop premises. There was a push pull door and a small ramp to provide reasonable access for a wheelchair or those with mobility issues. There was a range of information leaflets available which reflected the needs of the local community. Services and opening hours were also advertised on the window.

The pharmacist used local knowledge to signpost people to other healthcare providers when required. The pharmacy used a dispensing audit trail which included use of dispensed by and checked by boxes. This helped identify who had completed each task. The pharmacy also used baskets during the dispensing process to reduce the risk of error. There were separate areas for the assembling and checking of prescriptions.

During the inspection the pharmacist was easily accessible and was seen counselling people about a range of matters. The pharmacy team could speak a range of languages to reflect the local community. The pharmacist said that he counselled people taking higher-risk medicines but didn't make a record of the advice given. He said they had a sticker to highlight prescriptions for warfarin but didn't have similar stickers for methotrexate and lithium. He knew the advice that he should give about pregnancy prevention to people in the at-risk group taking sodium valproate.

Each person who received their medicines in a multi-compartment compliance pack had a chart so that any changes or missing medicines could be easily managed. Some charts seen had medicines crossed through or changed. This made them harder to read and might cause confusion. Labels on the packs recorded the shape and colour of the medicine to allow easy identification. Patient information leaflets were not routinely sent. The pharmacy also dispensed medicines for five care homes; this seemed well managed. The pharmacy delivered medicines to some people. The recipient signed to confirm they had received a prescription to create an audit trail.

Fridge records showed that medicines requiring cold storage were stored correctly between 2 and 8 degrees Celsius. The current temperature was within range, but the maximum temperature was 14 degrees Celsius. The pharmacist said he would investigate. The dispenser explained that date checking was carried out every three months and showed the records in the dispensary. Short-dated stock had a sticker with the expiry date. Out-of-date medicines were put in yellow waste bins; a patient-returned CD register was in place. Most medicines were stored in their original containers. But there were quite a lot of loose blisters on the dispensary shelves. In addition, some original packs seen had blisters with different expiry and batch numbers in them and contained more than the expected number of medicines. Some packs contained blisters from different manufacturers. This may increase the risk of out-of-date medicines or medicines subject to a product recall being supplied. Only recognised wholesalers were used for the supply of medicines.

The pharmacy recorded the date of opening on all liquid medicines that had a short-dated expiry once opened to ensure that they were still appropriate to be supplied. If there wasn't a specific date, then the pharmacist said they would use the open bottle up to the original expiry date. The expiry date on a liquid medicine indicates how long a medicine can be used for unopened. Once opened a medicine may deteriorate and the pharmacist should consider the time the bottle has been opened before making a supply.

The pharmacist said that they were registered with a company to implement the Falsified Medicines Directive but were waiting for the scanners. The pharmacist was aware of the action that should be taken to keep people safe following a drug alert. The pharmacy had stopped printing out the alerts in January 2019 which meant there was no longer an audit trail to show what action had been taken. The pharmacist said that he would re-introduce this process.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has access to the appropriate equipment and facilities to provide the services that it offers. It largely maintains its equipment and facilities adequately.

Inspector's evidence

The pharmacy had up to date reference sources. The pharmacy used crown marked measures for measuring liquids. There were separate measures for CDs. The fridge was in working order with the current temperature within the required range. CDs were stored securely.

The pharmacy's portable appliance electrical equipment test certificate had expired in July 2019. The pharmacist said he would speak to the superintendent to see if another test had been arranged. The pharmacist said that the blood pressure monitor was calibrated every two years and it had a sticker saying it had been calibrated in October 2017. The pharmacist said that the blood glucose monitor was not regularly calibrated. He said he would arrange for the monitor to be calibrated or replaced.

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.