General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Portway Pharmacy, Tividale Family Practice, 51A New Birmingham Road, Tividale, OLDBURY, West Midlands, B69 2JQ

Pharmacy reference: 1102845

Type of pharmacy: Community

Date of inspection: 24/10/2019

Pharmacy context

The pharmacy is located next to an opticians, in a residential area of Oldbury. Most people who use the pharmacy are from the local area. It dispenses prescriptions and sells a small range of over-the-counter (OTC) medicines. It also supplies some medicines in multi-compartment compliance aid packs to help make sure that people take them at the correct time. The pharmacy provides several other services including Medicines Use Reviews (MURs), a minor ailments service and flu vaccinations, when the pharmacy owner is present. A substance misuse treatment service is also available.

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 not all met	2.2	Standard not met	Pharmacy team members do not always hold the appropriate qualifications for their roles. So, the pharmacy cannot always demonstrate that they have the necessary skills for the tasks that they complete.
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 asks for feedback on its services. It keeps the records it needs to by law, but information is sometimes missing or inaccurate so, team members might not always be able to show what happened in the event of a query. The pharmacy team members understand their role and how to keep people's private information safe. And they complete safeguarding training to help protect the wellbeing of vulnerable people.

Inspector's evidence

A set of standard operating procedures (SOPs) covered operational services and defined staff responsibilities. The procedures had not been reviewed for several years, so may not always reflect current practice. The pharmacy owner reported that the review process was ongoing at the time of the inspection. Audit trails to confirm staff acknowledgement and understanding were incomplete. One team member explained that she had signed the procedures at another branch. The team members present were clear on their roles and a trainee dispenser correctely described the activities which were permissible in the absence of a responsible pharmacist (RP). Professional indemnity insurance covered pharmacy services.

The pharmacy had a near miss log, but the last recorded entry was dated 2018. The team reported that there was another log in use with some more recent entries, but this could not be located on the day. They explained that some near misses may not always be captured, which may mean that some underlying trends are not detected. The pharmacist discussed learning points that she had reinforced to staff following a near miss with digoxin prior to the inspector's arrival. This near miss had not yet been recorded. Examples were given where different strengths of medications had been separated in response to previous incidents. The pharmacist was not aware of any recent dispensing incidents. She explained the actions that she would take in response to an error and said that errors would be reported through the National Reporting and Learning System (NRLS).

The pharmacy had a complaint procedure, but this was not advertised so people may not always be aware of how concerns can be raised. It sought additional feedback through a Community Pharmacy Patient Questionnaire (CPPQ) and had also previously registered to receive Google reviews. A sticker advertising this had been placed on the entrance door and nine reviews had been received to date.

The RP notice was conspicuously displayed near to the medicine counter. The RP log was kept electronically and there were several instances where the time RP duties ceased was not recorded. In the sample portion viewed there was also a missing entry for Saturday 7 September 2019, and entries for Tuesday 24 September 2019 and Tuesday 8 October were incomplete, with an RP only recorded as present for half a day. The pharmacy's private prescription and emergency supply records were in order. Specials procurement records were available, but they did not always record an audit trail from source to supply.

Controlled Drugs (CD) registers recorded a running balance, but some headings were missing, so they

were not fully compliant with requirements. A patient returns CD register was available.

The pharmacy was registered with the Information Commissioner's Office (ICO), but a copy of its privacy policy was not seen on the day. The team did not recall any recent training on confidentiality and data protection but discussed some of the ways in which they would help to keep people's private information safe. Confidential waste was segregated and taken for appropriate disposal and tote boxes were used to store completed prescriptions and minimise visibility from the medicine counter. The pharmacist and one of the dispensers had an NHS smartcard. On the day, the smartcard of the pharmacy owner was being used in a dispensing terminal to access the NHS spine. This demonstrates that cards are not always suitably secured when not in use and could compromise the audit trail, used to show that access to confidential patient data is legitimate.

Pharmacy team members had completed some safeguarding training using a Numark training module and the pharmacist had completed additional training through the Centre for Pharmacy Postgraduate Education (CPPE). A dispenser discussed some of the types of concerns that might be identified and explained how they would be escalated. The pharmacy had not previously raised any concerns, but the contact details of local safeguarding agencies were accessible, if required.

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

Summary findings

Pharmacy team members are usually able to manage the dispensing workload. But they do not always hold the appropriate qualifications for the roles in which they are working. And the pharmacy does not provide them with protected learning time to effectively support their training. Feedback on their development is also limited so, the pharmacy is not not always be able to show that its team members have the appropriate skills, or that it identifies and addresses their development needs.

Inspector's evidence

On the day of the inspection, one of the regular pharmacists was working alongside two dispensers. The pharmacist worked two half-day shifts and the remainder of the week was covered by two other regular pharmacists, one of whom was the owner. This was the usual staffing level at the pharmacy. Leave was usually planned and a member of staff from a nearby branch would provide cover each Tuesday when the trainee was at college and also for other periods of leave. Cover was not always available for unplanned absences. In these instances, the pharmacist would work alongside one dispenser. The team were up to date with the current dispensing workload. But the workload could become more challenging if another team member was unexpectedly absent.

One of the dispensers was a trainee who was enrolled on a training programme through a local college. The second dispenser had previously been enrolled on a training course through Buttercups but had not completed this. The time period allowed for completion had now elapsed and the dispenser explained that she needed to re-enrol on the programme. But this had not yet been done. There was some limited ongoing training and development in the pharmacy. Team members reported that they read materials provided by Numark to keep their knowledge up to date. This took place on an ad hoc basis and a recent module covered focussed on digestive health. No training records were maintained as a record of this and there was no planned training time. The trainee had regular reviews with her college tutor, who discussed progress with the regular pharmacists. There were no regular development reviews for other team members so learning needs may not always be identified and addressed.

The trainee dispenser discussed the questions that she would ask to help make sure that sales of medicines were appropriate. She explained that she would approach the pharmacist if she was unsure and she identified some high-risk medicines which may be susceptible to abuse. And said that she would look to identify people who were making frequent requests for medicines. Concerns were referred to the pharmacist.

There was an open dialogue amongst the pharmacy team members on the day. All team members were also comfortable to approach the owner with any concerns, but at times it was felt that issues raised were not always swiftly addressed. The pharmacist confirmed that there were no targets in place for professional services.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is in a suitable state of repair. It has a consultation room to enable it to provide members of the public with access to an area for private and confidential discussions. But the lack of space does mean some areas are less well organised and this impacts on the working enviroment.

Inspector's evidence

The pharmacy's premises were in a reasonable state of repair. The pharmacy owner was responsible for arranging any necessary repair works. He had been informed of a broken smoke detector several weeks prior to the inspection but had not yet arranged for this to be resolved. There was adequate lighting throughout the premises and the temperature was suitable for the storage of medicines.

There was a small retail area to the front of the premises, which stocked a small range of products which were suitable for a healthcare-based business. Pharmacy restricted medicines were secured from self-selection behind the medicine counter. A chair could be used by people who were waiting for their medicines and the walkways were free from obstructions.

Off the retail area was a signposted and enclosed consultation room. The room was fitted with a desk and seating, but was cluttered with boxes, previous display materials and excess boxes of leaflets, which detracted from the overall professional appearance.

The dispensary was compact, there were some boxes temporarily being stored on the floor which may cause a trip hazard to team members. There was one main work bench with two computer terminals available. Dispensing took place at one end and checking at the other. Another work bench over the other side of the dispensary, provided some additional space if required and was where the pharmacy sink was located. Suitable handwashing and cleaning materials were available.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's services are suitably managed. It sources and handles medicines appropriately. But it could do more to demonstrate that it manages all of its medicines effectively. And team members are not always familiar with some aspects of the service delivery, which could affect the continuity of the services.

Inspector's evidence

The pharmacy entrance was step-free, and the manual door was visible from the medicine counter, enabling those who required assistance to be identified. There was limited advertisement of the pharmacy's services and a practice leaflet was not available on the day. A small healthy living space provided some health promotion literature on the appropriate use of antibiotics. The pharmacy team had access to some signposting materials, including contact numbers for the collection of sharps bins and local family planning clinics. Requests for other services were referred to the pharmacist.

Prescriptions were dispensed using baskets to keep them separate. Dispensing labels were not always signed by dispensers, so a complete audit trail identifying those involved in the dispensing process was not always available. The pharmacy used stickers to identify prescriptions for CDs to help make sure a supply was made within a valid 28-day expiry date. But they did not systemtically counsel people receiving high-risk medications and the pharmacy did not routinely keep records of monitoring parameters such as INR readings. The pharmacist was aware of the risks of valproate-based medicines in people who may become pregnant and of the requirements to supply the relevant safety literature. Copies of literature such as alerts cards could not be located on the day. The inspector advised on how further copies could be obtained and the pharmacy confirmed that they did not currently have a patient who met the at-risk criteria.

The pharmacy requested repeat medications for a limited number of patients in the area. They kept a basic audit trail of requests which had been sent off and received back from the surgery, to help identify unreturned prescriptions. Signatures were not routinely obtained to confirming the secure delivery of medicines. This included on separate CD delivery sheets. In most instances, only the delivery drivers' initials were recorded. This was discussed with the pharmacist who agreed to review this moving forward.

Medications for people using multi-compartment compliance aid packs were ordered on a cyclical basis. The pharmacy kept a list which recorded when compliance aid packs were due, so that a re-order date could be calculated. Records of medications in compliance packs were held on the pharmacy computer system. No high-risk medicines were placed into compliance packs and a dispenser said that she would check with the pharmacist if she was unsure. Completed packs had a backing sheet which contained a description of medicines. Some descriptions were missing in the example viewed and the backing sheet was not sealed to the tray, so it may become separated, which could make it difficult to identify, as there were no additional dispensing labels recording patient name. Patient leaflets were supplied. In the weeks prior to the inspection the pharmacy owner had taken on a contract to supply medicines to a small 11-bed care home. A dispenser was aware that patient prescriptions were managed using repeat dispensing, but nobody present was familiar with the supply process, which involved the use of

additional computer software. This could mean that in the absence of the pharmacy owner, there are not enough trained staff to enable the service to be provided effectively. The pharmacist on the day said that she believed that with time training would be provided to all team members.

The pharmacy owner was qualified for the provision of flu vaccinations and worked at the branch each Friday, which limited service availability. No vaccinations had been administered to date. The team reported that the owner was due to discuss the service with local GP surgeries.

Stock medicines were obtained through licensed wholesalers and specials from a licensed manufacturer. Medications were stored in a generally organised manner and in the original packaging provided by the manufacturer. Date checking records indicated that some checks had taken place in February 2019. The trainee dispenser explained that she had carried out more checks over the Summer months, but a record of this had not been kept. Short dated medicines were highlighted, and no expired medicines were identified from random checks. Obsolete medicines were stored in medicine waste bins. The pharmacy was not yet compliant with the requirements of the European Falsified Medicines Directive (FMD). The team were unaware of any new hardware or software being available to enable compliance and had not been provided with an indication of when the pharmacy owner was going to implement measures to become compliant. Alerts for the recall of faulty medicines and medical devices were received electronically. They were mainly managed by the pharmacy owner and team members were unaware of how to action the alerts in his absence. A folder had been created to keep an audit trail demonstrating that appropriate action had been taken in response to alerts, but this was not being used.

CDs were stored in an organised manner, with returned and expired medicines segregated from stock and CD denaturing kits were available for use. CD checks were not conducted as thoroughly as they could be. The pharmacy fridge had a maximum and minimum thermometer and the temperature was checked and recorded each day. It was within the recommended temperature range on the day.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs to provide its services. And the equipment appears suitably maintained.

Inspector's evidence

The pharmacy had access to a paper edition of the British National Formulary (BNF) and Drug Tariff. General internet access was also available for further research. Glass crown-stamped measures were available for measuring liquids. The measures were clearly marked to indicate their use with different liquids. Counting triangles were available for loose tablets and a separate triangle was marked for use with cytotoxic medicines.

Testing of some of the pharmacy's equipment, such as the fire extinguisher was overdue. The computer systems were in working order and were password protected, as was the PMR system. Cordless phones were available to enable conversations to take place in private, if necessary.

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.