General Pharmaceutical Council

# Registered pharmacy inspection report

**Pharmacy Name:** Westpoint Pharmacy, 10 Kingsway, MANCHESTER, Lancashire, M19 2DD

**Pharmacy reference:** 1103044

**Type of pharmacy:** Community

**Date of inspection:** 15/08/2019

## Pharmacy context

This is a community pharmacy that opens early in the morning and closes late at night. It is situated on a shopping-parade along a main road in an urban residential area, serving the local population. It mainly prepares NHS prescription medicines and orders repeat prescriptions on behalf of people. It has a home delivery service and prepares some medicines in weekly compliance packs to help make sure people take their medicines safely. The pharmacy also provides other NHS services such as minor ailment consultations.

## 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 takes some steps to manage its risks. It provides the pharmacy team with written instructions to help make sure it provides safe services. The team usually records and reviews its mistakes so that it can learn from them, and it keeps people's information secure. The team also has some understanding of its role in protecting and supporting vulnerable people.

### Inspector's evidence

The pharmacy had current written procedures that covered safe dispensing, the responsible pharmacist (RP) regulations and controlled drugs (CDs). However, staff had not read the RP procedures. And the CD procedures did not make clear which team members they applied to. So, team members may not always know how to complete tasks or work effectively.

Several randomly selected dispensed medicines indicated that either the dispenser or checker did not always initial the dispensing label. This could make it difficult clarifying who was responsible for each prescription medication supplied, as well as investigating and managing any mistakes.

The pharmacy team discussed and recorded mistakes it identified when dispensing medicines, and it addressed each of these mistakes separately. The RP, who was the resident and superintendent pharmacist reviewed these records every three months and shared their findings with the rest of the team. However, staff usually did not record the reason why they thought they had made each mistake. So, it could be harder for the team to identify trends and mitigate risks in the dispensing process.

A public notice explained how people could make a complaint and the pharmacy had a written procedure for handling and recording complaints. The RP said that staff had read the procedure, but they did not have a record to support this.

The pharmacy had professional indemnity insurance for the services it provided. The RP displayed their RP notice, but it was obscured from view, which could make it difficult for people to identify them. The pharmacy maintained its records required by law for private prescriptions and emergency supplies and preserved its records for CD destructions. The RP record stated the week it commenced, and each entry had the day of the week it was in relation to. However, each entry did not include the date that the RP started and finished, as required by law. The pharmacy kept records of the specials medications it had supplied but did not always record the people to who it supplied them. These gaps in the records could make it harder for the team to explain what has happened in the event of a query

Staff had signed confidentiality agreements and the pharmacy owner had registered with the Information Commissioner's Office (ICO). Staff securely stored and destroyed confidential material, used passwords to protect access to electronic patient data, and they each used their own security card to access people's electronic NHS data. So, it should be clear who had accessed this information. The pharmacy publicly displayed its privacy notice. And it had written guidance on GDPR, but staff said they had not read it. And the pharmacy had not formally audited its ability to protect people's data.

The pharmacy had informally assessed people when they started to use the compliance pack service

and limited some of them to seven days' medication per supply, which could help them to avoid becoming confused. However, it did not keep records supporting why it was safe to supply twenty-eight days' medication to other people in a single supply. Staff recalled consulting the GP when they suspected people had become confused but did not always take appropriate action such as limiting them to seven days' medication per supply when their concerns were confirmed.

The Pharmacy had the local safeguarding board's contact details and their policies and procedures for children. And it had its own procedures for safeguarding vulnerable adults but did not have the safeguarding board's procedures for safeguarding this group of people. All the pharmacists had level 2 safeguarding accreditation, but the other staff had not received any formal training appropriate for their role.

## Principle 2 - Staffing ✔ Standards met

### Summary findings

The pharmacy has enough staff to provide safe services. Team members work well together and complete training so that they have the qualifications and skills necessary for their roles. But qualified staff do not complete much ongoing training to make sure they maintain and develop their knowledge and skills.

### Inspector's evidence

The staff present were the RP who covered Monday to Thursday, an experienced dispenser, a medicines counter assistant (MCA) who was training to be a dispenser and another MCA. The pharmacy's other staff included a locum pharmacist who provided two days cover, a pharmacy undergraduate covering weekends, and a delivery driver.

The pharmacy had enough staff to comfortably manage its workload. The team usually had repeat prescription medicines, including those dispensed in compliance packs ready in good time for when people needed them. The pharmacy received most of its prescriptions via its prescription ordering and electronic prescription services, which helped to maintain service efficiency. And it had a low footfall, so the team avoided sustained periods of increased workload pressure and it could promptly serve people.

The pharmacist usually worked alone in the dispensary during the week from 7pm to 10.30pm, on Saturday from 6pm to 10.30pm and most of Sunday when the pharmacy usually received very few prescriptions. It occasionally had a short but busy period between 7pm and 8pm on two weekday evenings when the local GP issued acute prescriptions. During this time up to ten people might present during the whole hour, and the dispenser usually stayed until the service demand calmed down.

Staff worked well both independently and collectively. They used their initiative to get on with their assigned roles, did not need constant management or supervision and the dispenser and trainee dispenser provided the compliance pack service. The pharmacy effectively maintained services during staff leave. It only allowed one team member to be on leave at any one time and the undergraduate provided cover during these periods, which meant the pharmacy could maintain continuity of its services.

The MCA's dispenser training was progressing well since starting it in October 2018, with them scheduled to complete the course shortly. And each team member had a regular performance appraisal. However, qualified staff did not participate in any ongoing training programme for maintaining and developing their skills and knowledge.

The RP said that the pharmacy had no formal targets or incentives for its services. And the team could comfortably manage the competing MUR and dispensing workloads. They also said that they usually took between ten and twenty minutes on each MUR consultation depending on their complexity and completed them in the pharmacy's consultation room. So, they conducted them in an appropriate time and place.

The pharmacy usually obtained people's written consent for the electronic prescription service (EPS), although some people provided verbal consent instead. It only obtained people's verbal consent to provide the prescription ordering service. Which means the pharmacy may not always be able to effectively confirm that these people elected to use their services.

## Principle 3 - Premises ✔ Standards met

### Summary findings

The premises are clean, safe, secure and spacious enough for the pharmacy’s services. It has a private consultation room, so members of the public can have confidential conversations.

### Inspector's evidence

The level of cleanliness was appropriate for the services provided. The premises had the space that the team needed to dispense medicines safely. And staff could secure it to prevent unauthorised access. The consultation room provided the privacy necessary to enable confidential discussion. But its availability was not prominently advertised, so people may not always be aware of this facility.

## Principle 4 - Services ✔ Standards met

### Summary findings

The pharmacy's working practices generally help make sure people receive safe services. It gets its medicines from licensed suppliers and manages them effectively to make sure they are in good condition and suitable to supply.

### Inspector's evidence

The pharmacy was open extended hours across the week. It had a step-free entrance and the team could see people entering the premises, so they could easily access its services.

The pharmacy had a written procedure for dispensing higher-risk medicines that covered anticoagulants, lithium, and insulin. The RP said that he had briefed staff on dispensing valproate, but the pharmacy did not have a corresponding written procedure for them to read. He also said that the pharmacy did not have any people on valproate who could be in the at-risk group, but he had not completed a formal audit that could support this. The RP had the MHRA approved valproate advice booklets and cards to give people, but these were the January 2016 issue, not the updated May 2018 version.

The pharmacy regularly checked whether people on anti-coagulants, methotrexate and lithium had a recent blood test. And they regularly checked whether any of these people were experiencing side effects or medicine interactions when dispensing each prescription and counselled them if necessary. So, people on higher-risk medicines received the information they needed when necessary.

The pharmacy team prompted people to confirm the repeat medications they required on their next prescription. This helped it limit medication wastage and people received their medication on time. However, it did not keep any records of these requests. So, it could find it difficult to effectively resolve queries if needed.

The pharmacy team scheduled when to order prescriptions for people using compliance packs, so it could supply their medication in good time. The team also kept a record of their current medication that also stated the time of day they should take them, which should have helped it to identify and query any medications changes with the GP surgery. However, the team usually did not query these changes and it did not keep records of verbal communications about changes it did query, which could cause confusion and might lead to overlooking prescribing errors. The pharmacy also did not label most compliance packs with descriptions of each medicine inside them, so people may have difficulties identifying all their medicines.

The pharmacy team used baskets during the dispensing process to separate people's medicines, which helped it to organise its workload. The team most of the time only left a protruding flap on medication stock cartons to signify they were part-used, which could increase the risk of people receiving the incorrect medication quantity.

The pharmacy obtained its medicines from a range of MHRA licensed pharmaceutical wholesalers, which it stored in their original packaging and in an organised manner. It had registered itself with the organisation responsible for establishing the Falsified Medicines Directive (FMD). However, its system

for complying with the FMD was malfunctioning, so the pharmacy was not FMD compliant. The RP said they had reported the fault around two weeks ago, which the system provider said they would address.

The pharmacy suitably secured its CDs, properly segregated its date-expired and patient-returned CDs and it had destruction kits for destroying them. The team suitably monitored the medication refrigerator storage temperatures. Records indicated that the pharmacy had regularly monitored its stock expiry dates up until March 2019, and the RP said the team had completed further checks since that time but had not recorded them. The RP also said that the team took appropriate action when it received alerts for medicines suspected of not being fit for purpose but did not always record the action that it had taken. It disposed of obsolete medicines in waste bins kept away from medicines stock. So, the pharmacy reduced the risk of supplying medicines that might be unsuitable.

The RP said that the pharmacist checked the deadline date when they supplied CDs, including those owed to people, which made sure the pharmacy only supplied them when it had a valid prescription. However, the pharmacist did not always record their own details against each supply entry in the CD register. So, the pharmacy may not be able to effectively handle any queries that arose, including those that it had delivered. The team used an alpha-numeric system to store bags of dispensed medication. This meant staff could efficiently retrieve people's medicines when needed.

## Principle 5 - Equipment and facilities ✔ Standards met

### Summary findings

The pharmacy has the equipment and facilities that it needs to provide its services effectively. And it properly secures people's information.

### Inspector's evidence

The pharmacy team kept the dispensary sink clean. It had hot and cold running water and an antibacterial hand-sanitiser. The team also had a range of clean measures, including separate ones for methadone. So, it had the facilities to make sure it did not contaminate the medicines it handled and could accurately measure and give people their prescribed volume of medicine. The pharmacists had access to the electronic medicines compendium (eMC), which meant they could give people current information about their medicine.

The pharmacy team viewed people's electronic information on screens that were not visible from public areas. And the pharmacy regularly backed up data on its patient medication record (PMR) system. So, it secured people's electronic information and could retrieve their data if the PMR system failed. And it had facilities to store peoples dispensed medicines and their prescriptions away from public view.

## 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. |