

Registered pharmacy inspection report

Pharmacy Name: Davey's Chemist, Blue Bell HCRC, Blue Bell Lane, Huyton, LIVERPOOL, Merseyside, L36 7XY

Pharmacy reference: 1104308

Type of pharmacy: Community

Date of inspection: 22/10/2019

Pharmacy context

This is a community pharmacy inside a medical centre. It is situated in a residential area of Huyton in Knowsley. The pharmacy dispenses NHS prescriptions, private prescriptions and sells over-the-counter medicines. It also provides a range of services including seasonal flu vaccinations, a minor ailment service and a smoking cessation service. A number of people receive their medicines in multi-compartment compliance aids.

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

Members of the pharmacy team follow written procedures to help them work effectively. They record their mistakes so that they can learn from them. But they don't record everything that goes wrong, so they may miss some learning opportunities. The pharmacy generally keeps the records it needs to by law. And staff understand that confidential information needs to be protected.

Inspector's evidence

There was a set of standard operating procedures (SOPs) which were due to be reviewed in March 2018. Members of the pharmacy team had signed the SOPs to say they had read and accepted them. There were no SOPs related to working in the absence of the responsible pharmacist (RP). This means people who work in the pharmacy may not know what to do in those circumstances to make sure they don't break the law. But, when questioned, a dispenser was clear about the tasks that could or could not be conducted during the pharmacist's absence.

Dispensing errors were recorded electronically. The most recent error involved the supply of an incorrect insulin product. The pharmacist had investigated the error and action had been taken to help reduce the risk of similar errors. For example, members of the pharmacy team had been asked to conduct three dispensing checks in future when they dispensed insulin. Near miss errors were also recorded electronically. The pharmacist said she would review the records each month to identify learning points and discuss these with staff. But she did not think all of the near miss errors had been recorded. She said she would also highlight mistakes to staff at the point of accuracy check and ask them to rectify their own errors. She gave examples of action taken to help prevent similar mistakes, such as dispensing larger prescriptions away from the front counter to reduce distractions.

Roles and responsibilities of the pharmacy team were described in individual SOPs. A dispenser was able to describe what her responsibilities were. Staff wore standard uniforms. The RP had their notice displayed prominently. The pharmacy had a complaints procedure. But details about it were not on display so people may not always know how they can raise concerns. Complaints were recorded and followed up by the pharmacist or SI. A current certificate of professional indemnity insurance was seen.

Records for the RP, private prescriptions and emergency supplies appeared to be in order. Controlled drugs (CDs) registers were maintained with running balances recorded and usually checked every two weeks. A spot check of two balances found a discrepancy. The pharmacist promptly identified this as a duplicated record and it was rectified. A patient returned CD register was available. Records of unlicensed specials did not always contain the required details of when they were supplied and to whom.

Information governance (IG) procedures were in place. A dispenser said she had read IG procedures and signed a confidentiality agreement. But staff were not aware about the updated requirements of data protection for GDPR. So they may not fully understand their current responsibilities. When questioned, the dispenser was able to describe how confidential waste was segregated to be destroyed using an on-site shredder. There was no privacy notice on display, so people may not always be fully informed how their information is handled.

Safeguarding procedures were included in the SOPs. The pharmacy team had completed in-house training and the pharmacist said she had completed level 2 safeguarding training. Contact details of the local safeguarding board were on display. A technician said she would initially report any concerns to the pharmacist on duty.

Principle 2 - Staffing ✓ Standards met

Summary findings

There are enough staff to manage the pharmacy's workload and they are appropriately trained for the jobs they do. Members of the pharmacy team complete some additional training to help them keep their knowledge up to date.

Inspector's evidence

The pharmacy team included a pharmacist manager, a pre-registration pharmacist (pre-reg), a pharmacy technician who was trained to accuracy check (ACT), a pharmacy technician, and two dispensers. All members of the team had completed the necessary training for their roles. The normal staffing level was a pharmacist, a pre-reg, an ACT, and three other staff. The volume of work appeared to be managed. Staffing levels were maintained by a staggered holiday system and relief staff from nearby branches.

Members of the pharmacy team completed some additional training, for example they had recently completed a training pack about Children's oral health. Staff were allowed learning time to complete training. But further training was not provided in a structured or consistent manner, and records were not always kept. So learning needs may not always be fully addressed.

The dispenser gave examples of how she would sell a pharmacy only medicine using the WWHAM questioning technique, refuse co-codamol sales she felt were inappropriate and refer people to the pharmacist if needed. The pharmacist said she felt able to exercise her professional judgement and this was respected by the pharmacy team and SI. A technician said she felt she received a good level of support and was able to ask for further help if she needed it. Staff appraisals had not been provided, so specific learning and development needs may be missed. Staff were aware of the whistleblowing policy and said that they would be comfortable reporting any concerns to the SI. The pharmacist said she did not feel under pressure to achieve any service-based targets.

Principle 3 - Premises ✓ Standards met

Summary findings

The pharmacy premises are suitable for the services provided. A consultation room is available to enable private conversations.

Inspector's evidence

The pharmacy was generally clean and appeared adequately maintained. The size of the dispensary was sufficient for the workload. A sink was available within the dispensary. The temperature was controlled by the use of air conditioning units. Lighting was sufficient. The staff had access to a kettle and WC facilities.

A consultation room was available. The space was cluttered with boxes and used as storage. There was a computer, desk, seating, and adequate lighting. The patient entrance to the consultation room was clearly signposted.

Principle 4 - Services ✓ Standards met

Summary findings

The pharmacy's services are easy to access. And it manages them effectively. But members of the pharmacy team do not always know when higher-risk medicines are being handed out. So they might not always check that the medicines are still suitable, or give people advice about taking them. The pharmacy team carries out some checks to make sure medicines are in good condition. But it does not always keep records so it can't show that the checks have been done properly.

Inspector's evidence

Access to the pharmacy was suitable for wheelchair users. There was also wheelchair access to the consultation room. There was limited information on display about the services offered or the times the pharmacy was open. So people may not always be aware of what services they can access and when. There was some information available on the pharmacy's website.

The pharmacy had a delivery service. Deliveries were segregated after their accuracy check and logged onto an electronic delivery management system. A mobile device belonging to the pharmacy was used to obtain electronic signatures from the recipient to confirm delivery. Unsuccessful deliveries would be returned to the pharmacy and a card posted through the letterbox indicating the pharmacy had attempted a delivery.

The pharmacy team initialled dispensed by and checked by boxes on dispensing labels to provide an audit trail. They used dispensing baskets to separate individual patients' prescriptions to avoid items being mixed up and the baskets were colour coded to help prioritise dispensing. Owing slips were in use to provide an audit trail if the full quantity could not be immediately supplied. The pharmacist performed a clinical check of all prescriptions and then signed the prescription form to indicate this had been completed. When this had been done an ACT was able to perform the final accuracy check. Some dispensing baskets were stored on the floor, which may increase the risk of damage to these medicines.

Dispensed medicines awaiting collection were kept on a collection shelf using a numerical retrieval system. Prescription forms were retained, and stickers were used to clearly identify when fridge or CD safe storage items needed to be added. Staff were seen to confirm the patient's name and address when medicines were handed out. Schedule 3 and 4 CDs were not highlighted. So there was a risk that these medicines could be supplied after the prescription had expired. High-risk medicines (such as warfarin, lithium and methotrexate) were also not routinely highlighted. So the pharmacy team may not be aware when they are being handed out in order to check that the supply is suitable for the patient. The staff were aware of the risks associated with the use of valproate during pregnancy. Educational material was available to hand out when the medicines were supplied. The pharmacist said she would speak to any patients who were at risk and make them aware of the pregnancy prevention programme.

Some medicines were dispensed in multi-compartment compliance aids. Before people started receiving these, the pharmacy would refer them to their GP to assess if they were suitable. A record sheet was kept for each patient, containing details of their current medication. Any medication changes were confirmed with the GP surgery before the record sheet was amended. Hospital discharge sheets were sought, and previous records were retained for future reference. Disposable equipment was used

to provide the service, and the compliance aids were labelled with medication descriptions and a dispensing check audit trail. Patient information leaflets (PILs) were routinely supplied.

The pharmacy provided a flu vaccination service under a patient group directive (PGD). The pharmacist had completed the necessary training required by the PGD. Records of vaccination were kept, and the GP was informed following a vaccination.

Medicines were obtained from licensed wholesalers, and any unlicensed medicines were sourced from a specials manufacturer. The pharmacy was not yet meeting the safety features of the falsified medicine directive (FMD), which is now a legal requirement. Equipment was installed but the pharmacy team had yet to commence routine safety checks of medicines. The pharmacy team said that they would check the expiry dates of stock on a monthly basis. But this was not recorded so there is a risk some medicines may be overlooked. A spot check of the dispensary stock did not find any out of date medicines. Liquid medication did not always have the date of opening written on, including a bottle of Morphine sulphate oral solution which expired 3 months after opening. So members of the pharmacy team may not know how long the medicines had been open or whether they remained fit for purpose.

Controlled drugs were stored in the CD cabinet. This was very full and there was a large volume of out of date medicines which had not been destroyed for some time. This may increase the risk of a picking error. There was a clean medicines fridge with a minimum and maximum thermometer. The minimum and maximum temperature was being recorded daily and records showed they had been within the required range for the last 3 months. Patient returned medication was disposed of in designated bins located away from the dispensary. The pharmacist said she received drug alerts by email from the MHRA. But there were no records kept so the pharmacy was not able to show whether appropriate action had been taken.

Principle 5 - Equipment and facilities ✓ Standards met

Summary findings

The pharmacy's team members have access to the equipment they need for the services they provide. And they maintain the equipment so that it is safe to use.

Inspector's evidence

The staff had access to the internet for general information. This included access to the BNF, BNFc and drug tariff resources. All electrical equipment appeared to be in working order. There were no stickers attached to indicate they had been PAT tested. A dispensing robot was used to help assist the dispensing of medicines. This was serviced annually by the manufacturer and the pharmacy team said it was in good working order. There was a selection of liquid measures with British Standard and Crown marks. Separate measures were designated and used for methadone. The pharmacy also had counting triangles for counting loose tablets including a designated tablet triangle for cytotoxic medication. Equipment was kept clean by the pharmacy team.

Computers were password protected and screens were positioned so that they weren't visible from the public areas of the pharmacy. A cordless phone was available in the pharmacy which allowed the staff to move to a private area if the phone call warranted privacy. The consultation room was used appropriately; patients were offered its use when requesting advice or when counselling was 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.