General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Yewtree Chemist, 235 Finch Lane, Knotty Ash, LIVERPOOL, Merseyside, L14 4AE

Pharmacy reference: 1105306

Type of pharmacy: Community

Date of inspection: 29/07/2019

Pharmacy context

The pharmacy is located amongst other retail shops, in a residential area of Liverpool. The pharmacy premises are easily accessible for people, with adequate space in the consultation room and wide aisles in the retail area. The pharmacy sells a range of over-the-counter medicines and dispenses private and NHS prescriptions. The pharmacy stays open for 100 hours per week and is open late into the evening.

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 not all met	1.6	Standard not met	The pharmacy does not adequately maintain all of the records required by law, specifically the emergency supply record and the private prescription records.
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 not all met	4.3	Standard not met	The pharmacy does not carry out adequate checks to ensure that medicines are suitable for supply and stored appropriately, including date checking and temperature monitoring of the fridge used to store medicines. And some medicines are not stored as securely as they should be.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance **Standards not all met**

Summary findings

The pharmacy does not maintain all the records required by law and some important details are missing, which means the team may not be able to show exactly what has happened. Members of the pharmacy team are clear about their roles and responsibilities. But team members do not always record and review their mistakes, so they may miss learning opportunities.

Inspector's evidence

There were Standard Operating Procedures (SOPs) for the services provided, with signature sheets showing that members of staff had read and accepted them. Roles and responsibilities of staff were set out in SOPs. A dispenser was following the SOPs that were relevant to her role and was able to clearly describe her duties.

The dispenser said that dispensing incidents were reported by the superintendent on the computer system. She said near miss errors were reported on a near miss log, but this was not present. There was no evidence to suggest near miss errors were recorded or reviewed. The pharmacist said near misses were discussed with the pharmacy team member at the time of the error. The pharmacy team were unable to think of any near miss or dispensing errors that had occurred and explain how they had learnt from them.

The correct responsible pharmacist (RP) notice was displayed conspicuously in the pharmacy. The pharmacist explained that she aimed to resolve complaints in the pharmacy at the time they arose, but she would refer the customer to the superintendent if they felt it was unresolved. There was a complaints procedure in place, but there was no information displayed explaining how complaints would be dealt with. So, patients may be unsure how to raise a concern if they were unhappy with the service received.

A customer satisfaction survey was carried out annually. The dispenser explained that because of receiving some negative feedback about the prescription delivery service and the designated times for delivery not being suitable, the pharmacist often delivered prescriptions outside of the designated times, to help make sure patients receive their medicines at a time that was suitable for them.

The company had appropriate insurance in place. The specials procurement record, responsible pharmacist (RP) record and CD register were in order. Patient returned CDs were recorded and disposed of appropriately. The emergency supply record had the reason for supply missing from some entries. The private prescription record was not kept up to date in accordance with legal requirements, with approximately 50 private prescriptions not entered into the record since February 2018.

Confidential waste was shredded. Patient information was kept out of sight of patients and the public. All staff had read and signed confidentiality agreements as part of their employment contracts. The computers were password protected, facing away from the customer and assembled prescriptions awaiting collection were stored on shelves in the dispensary in a manner that protected patient information from being visible. There was no privacy notice displayed. So, patients and the public may be unaware how the pharmacy intended to use their personal data.

The pharmacist had completed level 2 safe guarding training. A copy of the LPC safe guarding guidelines were present. But there were no local contact details for seeking advice or raising a concern, which may make it more difficult for the pharmacy team in the event of a concern arising.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough staff to manage its workload safely. The team members are comfortable about providing feedback to the pharmacist. The pharmacy enables its team members to act on their own initiative and use their professional judgement, to the benefit of people who use the pharmacy's services. But the lack of formal ongoing training could mean their skills and knowledge may not always be up to date.

Inspector's evidence

There was a locum pharmacist, a dispenser and a medicines counter assistant on duty. The staff were busy providing pharmacy services and they appeared to manage the workload adequately.

The staff said the superintendent was the regular pharmacist, he was supportive and was more than happy to answer any questions they had. The dispenser explained that no ongoing training material was provided. Therefore, the lack of a regular training programme might restrict the ability of staff to keep up to date.

The staff were aware of a process for whistle blowing and knew how to report concerns about a member of staff if needed. Staff were regularly given feedback informally from the pharmacist. For example, about near miss errors.

The medicines counter assistant was clear about her role. She knew what questions to ask when making a sale and when to refer the patient to a pharmacist. She was clear which medicines could be sold in the presence and absence of a pharmacist and was clear what action to take if she suspected a customer might be abusing medicines such as Nytol, which she would refer the patient to the pharmacist for advice. The pharmacist explained that there were no formal targets or incentives set for the professional services, in her role as a locum.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean and generally tidy. It is a suitable place to provide healthcare.

Inspector's evidence

The pharmacy was clean and generally tidy. It was free from obstructions and had a waiting area. The dispenser said that dispensary benches, the sink and floors were cleaned regularly.

The temperature in the pharmacy was controlled by heating units. Lighting was adequate. The pharmacy premises were maintained and in an adequate state of repair. Maintenance problems were reported to the pharmacist and dealt with. Staff facilities included a microwave, kettle and toaster, WC with wash hand basin and antibacterial hand wash.

There was a consultation room available which had a large amount of excess retail stock stored inside. There was one chair and no desk. The pharmacist said that another chair would be added to the room when necessary for service provision. The door to the consultation room had a large clear glass window, which may increase the possibility of a breach to patient confidentiality occurring.

Principle 4 - Services **Standards not all met**

Summary findings

The pharmacy obtains medicines from reputable suppliers. But it does not always manage these adequately or complete enough checks to make sure that medicines are suitable for supply and stored appropriately. The pharmacy's services are easy to access, and they are generally well managed. But members of the pharmacy team do not always know when high-risk medicines are being handed out. So, they may not always make extra checks or give people advice about how to take them.

Inspector's evidence

The pharmacy, consultation room and pharmacy counter were accessible to all, including patients with mobility difficulties and wheelchairs. There was a selection of healthcare leaflets. Staff were clear about what services were offered and where to signpost to a service if this was not provided. For example, needle exchange. The opening hours were displayed near the entrance.

The work flow in the pharmacy was organised into separate areas, with an assembly area for multi-compartment compliance aids, adequate dispensing bench space and a checking area for the pharmacist. Dispensed by and checked by boxes were initialled on the medication labels to provide an audit trail. Baskets were used in the dispensary to separate prescriptions to reduce the risk of medicines becoming mixed up during dispensing.

A dispenser explained that prescriptions containing schedule 2 CDs had a note included on the assembled bag. She explained that this was to act as a prompt for staff to remove the CD from the CD cabinet and include it with the rest of the assembled prescription at the time of supply. Assembled schedule 3 and 4 CDs awaiting collection were not currently highlighted, which may increase the possibility of supplying a CD on a prescription that had expired.

Prescriptions containing high-risk medicines such as warfarin and lithium that were awaiting collection had not been highlighted. The pharmacist and dispenser were both aware of the safety alert for valproate. The pharmacy had no patient information resources for valproate and the staff were unaware whether a clinical audit for patients prescribed valproate had been carried out, which meant they may not be aware of patients currently prescribed valproate who met the risk criteria and may not be able to supply all of the necessary information if valproate was dispensed. The pharmacist said she would obtain the necessary patient information resources for the supply of valproate.

The dispenser provided a detailed explanation of how the multi-compartment compliance aid service was provided. The service was organised with an audit trail for changes to medication being added to the computer patient medication record (PMR). Disposable equipment was used. The assembled compliance aid packs awaiting collection had no individual medicine descriptions included. Patient information leaflets were present with some of the medicines supplied, but not all. So, patients may not be able to easily identify their medicines and may not always have the most up-to-date medicines information.

The dispenser explained how the prescription delivery service was provided. She said at present patient signatures were obtained for receipt of CDs delivered but not for other prescription deliveries. Therefore, the pharmacy would not have a robust audit trail for the supply for all medicines. The

dispenser said if a patient was not at home at the time of delivery a note was left, and the prescription was returned to the pharmacy.

Stock medications were sourced from reputable wholesalers and specials from a licensed manufacturer. Stock was generally stored tidily in the pharmacy, but there was a bottle of Oromorph 10mg / 5ml oral solution and a bottle of metoclopramide 5mg / 5ml solution with no dates of opening on. The dispenser said date checking was carried out and a record was kept, but this was not present. She said short dated medicines were highlighted, but a box of glyceryl trinitrate tablets 500mcg was not highlighted and had expired in February 2019 and a container of Adex Gel x 100g was not highlighted and had expired in June 2019, which increased the possibility of supplying a medicine that had expired.

Patient returned CDs were destroyed using denaturing kits and a record was kept. A balance check for a random CD was carried out and found to be correct. There was a clean fridge for medicines, equipped with a thermometer. The thermometers minimum temperature had been set as 0.2 degrees centigrade and the maximum temperature was set as 22.7 degrees centigrade. So, the pharmacy team would not be aware when the fridge was operating outside the normal range. The current temperature of the fridge was 3.3 degrees centigrade.

There was no software or hardware installed to allow the pharmacy to be compliant with the Falsified Medicines Directive (FMD). The pharmacist and dispenser said they were unaware when the pharmacy would become compliant. Therefore, the pharmacy was not meeting legal requirements. Alerts and recalls were received via email. The dispenser said these were actioned by the pharmacist or pharmacy team member, but no record was present, which means the pharmacy was not able to provide assurance that alerts and recalls were being appropriately dealt with.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy generally has the equipment it needs to provide the service safely.

Inspector's evidence

The staff used the internet to access websites for up to date information. For example, BNF, BNFc and Medicines Complete. Any problems with equipment were reported to the pharmacist. All electrical equipment appeared to be in working order but was not PAT tested for safety.

There was a selection of liquid measures with British Standard and Crown marks. A designated measure was used for methadone. The pharmacy had equipment for counting loose tablets and capsules, including tablet triangles and a Kirby FL9 electric tablet counter that was in working order.

There were two uncalibrated plastic measures which the dispenser said were no longer used and were appropriately disposed of at the time.

Computers were password protected and screens were positioned so that they weren't visible from the public areas of the pharmacy. Cordless telephones were available in the pharmacy and the staff said they used these to hold private conversations with patients when needed.

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.