General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Knights Winyates Pharmacy, Winyates Health Centre, Winyates Way, REDDITCH, Worcestershire, B98 0NR

Pharmacy reference: 1120925

Type of pharmacy: Community

Date of inspection: 13/01/2020

Pharmacy context

This is a community pharmacy in a shopping area and interconnected with a large health centre. It is located to the south-east of the town of Redditch. The pharmacy dispenses NHS and private prescriptions and sells over-the-counter medicines. It also supplies several medicines in multi-compartment aids to help vulnerable people in their own homes to take their medicines.

Overall inspection outcome

✔ **Standards met**

Required Action: None

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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	2.4	Good practice	The team members are encouraged to develop and keep their skills up to date and they are given time to do this at work.
		2.5	Good practice	The pharmacy team is well supported by the manager. They are comfortable about providing feedback to him to improve services for patients and he acts on this.
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's working practices are safe and effective. It is appropriately insured to protect people if things go wrong. The pharmacy keeps the up-to-date records that it must by law. The pharmacy team keep people's private information safe and they know how to protect vulnerable people. But, they could be better at recording and learning from mistakes to prevent them from happening again.

Inspector's evidence

The pharmacy team identified and managed most risks. All dispensing errors and incidents were recorded. The last error had occurred about eight weeks ago. Amlodipine had been given against a prescription calling for amitriptyline. All errors were reported to be thoroughly discussed but, the dispensing staff, except for the accuracy checking technician (ACT), could not recall the error. Near misses were recorded but insufficient information was documented to allow any useful analysis, such as, a levothyroxine strength error. It had not been documented what was on the prescription and what was picked. No learning points or actions taken to reduce the likelihood of similar recurrences were recorded. General trends could however be identified.

The dispensary was spacious and organised. There were dedicated areas for labelling, assembly, accuracy checking technician checking and pharmacist checking. There was a separate bench for the assembly of multi-compartment compliance aids. Coloured baskets were used and distinguished the prescriptions for patients who were waiting, those calling back, electronically transferred prescriptions for collection and those for delivery. Three independent people were involved in the dispensing process and this reduced the risk of errors. There was a clear audit trail of the dispensing process and all the 'dispensed by' and 'checked by' boxes, on the labels examined, except for assembled methadone, had been initialled. Assembled methadone only included the initials of the pharmacist. He said that, in future, he would ensure that all methadone was double-checked and that there was a completed dispensing audit trail to demonstrate this. Any prescriptions checked by the ACT had been previously clinically checked by the pharmacist and there was an audit trail demonstrating this.

Up-to-date, signed and relevant standard operating procedures (SOPs), including SOPs for services provided under patient group directions, were in place and these were reviewed every two years, or sooner, if necessary, by the superintendent pharmacist. The roles and responsibilities were set out in the SOPs and the staff were clear about their roles. The company's sales protocol was not displayed but a NVQ2 trainee dispenser said that she would refer anything that she was uncertain of to the pharmacist. A NVQ2 trained dispenser said that she would refer all medicine sale requests for patients who were pregnant and those for children under six to the pharmacist. She was aware of 'prescription only medicine' (POM) to 'pharmacy only medicine' (P) switches, such as hydrocortisone ointment and also referred requests for these to the pharmacist.

The staff were clear about the complaints procedure and reported that feedback on all concerns was encouraged. The pharmacy did an annual customer satisfaction survey. The pharmacist said that in the 2019 survey, most people were completely satisfied with the service from the pharmacy. However, the results of this survey were not displayed. The pharmacist did say that there had been some feedback about the management of the queue because there were two entrances to the premises. Because of this feedback, the staff informed people to queue from the surgery entrance side, this being where

most of their customers accessed the pharmacy.

Public liability and professional indemnity insurance, provided by the National Pharmacy Association and valid until 31 December 2020, was in place. The responsible pharmacist log, controlled drug (CD) records, including patient-returns, private prescription records, emergency supply records, specials records, fridge temperature records and date checking records were all in order.

An information governance procedure was in place and the staff had completed training on the general data protection regulations. The computers, which were not visible to the customers, were password protected. Confidential information was stored securely. Confidential waste paper information was shredded. No conversations could be overheard in the consultation room.

The staff understood safeguarding issues. The pharmacist and technician had completed the Centre for Pharmacy Postgraduate Education (CPPE) module on safeguarding. Local telephone numbers were available to escalate any concerns relating to both children and adults.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough staff to manage its workload safely. And, the company provides additional support when team members are on holiday or off sick. The team members are encouraged to develop and keep their skills up to date and they are given time to do this at work. Those team members who are in training are well supported by the manager. The team are comfortable about providing feedback to him to improve services for patients and he acts on this.

Inspector's evidence

The pharmacy was interconnected with a large health centre and located in a local shopping centre on the outskirts of Redditch. They mainly dispensed NHS prescriptions with the majority of these being repeats. But, due to the location, there were several acute 'walk-in' prescriptions. Several domiciliary patients received their medicines in multi-compartment compliance aids.

The current staffing profile was one pharmacist, the manager, one full-time accuracy checking technician (ACT), two full-time NVQ2 trained dispensers and one full-time NVQ2 trainee dispenser. One qualified dispenser was on extended leave and one had recently, the week before the visit, been signed off sick. Two pharmacists had been on duty the week before the visit to accommodate the latter. A second pharmacist or an ACT would replace the employed ACT when she was on holiday of off sick. If other staff were off, the ACT would do the assembly of medicines and a second pharmacist would be obtained to help with the checking of these. Planned leave was booked well in advance and only one member of staff could be off at one time. A staffing rota was used to ensure appropriate staffing levels with the desired skill mix.

The staff were well qualified and worked well together as a team. Staff performance was monitored, reviewed and discussed informally throughout the year. There was an annual performance appraisal where any learning needs could be identified. Review dates would be set to achieve this. The staff were encouraged with learning and development and completed regular monthly e-Learning, such as recently on verrucae. They said that they spent about 30 minutes each month of protected time learning. Staff enrolled on accredited courses, such as the NVQ2 dispensing assistant course, were allocated additional time for learning, usually when it was quiet. All the dispensary staff reported that they were supported to learn from errors. The GPhC registrants reported that all learning was documented on their continuing professional development (CPD) records.

The staff knew how to raise a concern and reported that this was encouraged and acted on. There had been a recent issue where the backing sheet for a compliance aid had not been correctly updated. Because of this, there was now an audit trail to demonstrate that the backing sheet had been checked against the prescription. There were 'ad hoc' staff meetings. The manager said that he would implement more formal monthly meetings where issues like errors and near misses could be thoroughly discussed.

The pharmacist reported that he was set overall targets, such as for Medicines Use Reviews (MURs). He said that he only did clinically appropriate reviews and did not feel unduly pressured by the targets.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy looks professional. The work areas are tidy, clean and organised. The pharmacy signposts its consultation room well, so it is clear to people that there is somewhere private for them to talk.

Inspector's evidence

The pharmacy was well laid out and presented a professional image. The dispensing benches were tidy and organised. The floors were clear. The premises were clean and well mainly maintained. The automatic push-button opening from the car park to the pharmacy was not working. The pharmacist said that he would report this to the company’s maintenance department.

The consultation room was spacious and well signposted. It contained a computer and a sink. There were two chairs but these were covered in fabric which meant that they may be difficult to keep clean. Conversations in the consultation room could not be overheard. The computer screens were not visible to customers. The telephone was cordless and all sensitive calls were taken in the consultation room or out of earshot.

The temperature in the pharmacy was below 25 degrees Celsius. There was good lighting throughout. Most items for sale were healthcare related.

Principle 4 - Services ✔ Standards met

Summary findings

Everyone can access the services the pharmacy offers. It generally manages the services effectively to make sure that they are delivered safely. The team members make sure that people have the information that they need to use their medicines properly. They intervene if they are worried or think that people may be suffering from side effects. The pharmacy gets its medicines from appropriate sources. And, it stores and disposes of them safely. The team members make sure that people only get medicines or devices that are safe.

Inspector's evidence

There was wheelchair access to the pharmacy and the consultation room with a push-button opening front door directly to the pharmacy and also access from the surgery. The staff could access an electronic translation application for use by non-English speakers and they spoke Urdu, Hindi, Romanian and Polish. The pharmacy could print large labels for sight-impaired patients.

Advanced and enhanced NHS services offered by the pharmacy were Medicines Use Reviews (MURs), New Medicine Service (NMS), supervised consumption of methadone and buprenorphine, emergency hormonal contraception (EHC), the Community Pharmacy Consultation Service (CPCS) and seasonal flu vaccinations. The latter was also provided under a private scheme. The staff were aware of the services offered. The pharmacist planned to meet with the adjacent surgery to discuss which further services would be beneficial for the local community.

The pharmacist had completed suitable training for the provision of seasonal flu vaccinations including face to face training on injection technique, needle stick injuries and anaphylaxis. He had also completed suitable training for the provision of the free NHS EHC service and the new CPCS service.

A few substance misuse patients had their medicines supervised and others took their medicines home. Any concerns about these patients were recorded on their electronic prescription medication record (PMR). The pharmacy did not have the telephone numbers of key workers and it was open when the service provider was closed. These numbers would therefore be useful. The supervised patients were offered water or engaged in conversation to reduce the likelihood of diversion.

Several domiciliary patients received their medicines in compliance aids. They were assembled on a four-week rolling basis and evenly distributed throughout the week to manage the workload. Changes in dose were mainly recorded but often not dated. This meant that the pharmacist did not have a clear clinical history of the patient at the checking stage. The assembled compliance aids were stored tidily. Procedures were in place to ensure that all patients who had their medicines in compliance aids and were prescribed high-risk drugs, were having the required blood tests.

There was a good audit trail for all items ordered on behalf of patients by the pharmacy and for all items dispensed (except methadone – see under principle 1) by the pharmacy. Interventions were seen to be recorded on the patient's PMR. Green 'see the pharmacist' stickers were used. The pharmacist routinely counselled patients prescribed high-risk drugs such as warfarin, lithium, azathioprine and cyclosporin. INR levels were asked about as were signs of potential side effects, such as, sore throats and fever in patients taking cytotoxic medicines. The pharmacist also counselled patients prescribed amongst others, antibiotics, new drugs and any changes. CDs and insulin were packed in clear bags and

these were checked with the patient on hand-out. All the staff were aware of the sodium valproate guidance relating to the pregnancy protection programme. Several 'at risk' patients had been identified and counselled. Guidance cards were included with each prescription for these patients.

All prescriptions containing potential drug interactions, changes in dose or new drugs were highlighted to the pharmacist. He clinically checked all prescriptions and so was also independently aware of these. Signatures were obtained indicating the safe delivery of all medicines and owing slips were used for any items owed to patients. Potential non-adherence or other issues were identified at ordering, labelling and hand-out. Any patients giving rise to concerns were targeted for counselling. The pharmacist reported that he identified, during MURs, that patients sometime forgot to take their medicines. He gave them advice on what to do if this was the case. He sometimes identified side effects, such as, a dry cough from angiotensin-converting enzyme I (ACE I) inhibitors. He referred these patients to their doctor and the medicines were often changed to ACE II inhibitors.

Medicines and medical devices were obtained from Lexon, AAH and Alliance Healthcare. Specials were obtained from Lexon Specials. Invoices for all these suppliers were available. CDs were stored tidily in accordance with the regulations and access to the cabinet was appropriate. There were no patient-returned CDs or out-of-date CDs. Appropriate destruction kits were on the premises. Fridge lines were correctly stored with electronic records. Date checking procedures were in place with signatures recording who had undertaken the task. Designated bins were available for medicine waste and used. There was a separate bin for cytotoxic and cytostatic substances and a list of such substances that should be treated as hazardous for waste purposes.

There was a procedure for dealing with concerns about medicines and medical devices. Drug alerts were received electronically, printed off and the stock checked. They were signed and dated by the person checking the alert. Any required actions were recorded. A concise audit sheet was also completed. The pharmacy had received an alert on 5 December 2019 about ranitidine tablets. They had none in stock and this was recorded.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the appropriate equipment and facilities for the services it provides. And, the team members make sure that they are clean and fit-for-purpose.

Inspector's evidence

The pharmacy used British Standard crown-stamped conical measures (10 to 250ml). There was an automatic tablet-counter and a tablet-counting triangle specifically for cytotoxic substances. The automatic tablet-counter container and the triangle were cleaned with each use. There were up-to-date reference books, including the British National Formulary (BNF) 78 and the 2019/2020 Children's BNF. There was access to the internet.

The fridge was in good working order and maximum and minimum temperatures were recorded daily. The pharmacy computers were password protected and not visible to the public. There was a cordless telephone and any sensitive calls were taken in the consultation room or out of earshot. Confidential waste information was shredded. The door was always closed when the consultation room was in use and no conversations could be overheard.

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.