General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: County Pharmacy, 13-15 Church Road, REDDITCH, Worcestershire, B97 4AB

Pharmacy reference: 1124405

Type of pharmacy: Community

Date of inspection: 20/01/2020

Pharmacy context

This is a community pharmacy in the centre of the town of Redditch close to three doctor's surgeries. A wide variety of people use the pharmacy but they are mainly elderly. It is open every day and for extended hours. The pharmacy dispenses NHS and private prescriptions and sells over-the-counter medicines. It also supplies several medicines in multi-compartment compliance 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	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's working practices are generally safe and effective. It is appropriately insured to protect people if things go wrong. The pharmacy mainly keeps the up-to-date records that it must by law. The pharmacy team members 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. Any dispensing error or incident was recorded, reviewed and appropriately managed. Near misses were recorded but insufficient information was documented to allow any useful analysis, such as a recent strength error regarding Sukkato. It had not been identified what was on the prescription and what had been picked. No learning points or actions taken to reduce the likelihood of similar recurrences were recorded. General trends could however be identified but the dispenser seen said that these were not thoroughly discussed with the staff.

The dispensary was large with labelling, assembly, waiting to be checked and checking areas. There were two central benches, one of which was used for wholesale stock to be put away. Coloured baskets were used and distinguished prescriptions for patients who were waiting, those calling back and those for delivery. There was mainly a clear audit trail of the dispensing process but the external medicines for a patient who had most of their medicines assembled into a multi-compartment compliance aid had no initials in the 'dispensed by' box on the labels. There was a completed dispensing audit trail on the compliance aid. Assembled methadone and buprenorphine, for supervised consumption, had no completed dispensing audit trail at all. The pharmacist seen, a locum, said that he had assembled and checked these medicines himself. He said that if future, a second independent person would be involved in the dispensing process and also that he would ensure that the labels contained a dispensing audit trail showing who had assembled the item and who had checked it.

Up-to-date, signed and relevant standard operating procedures (SOPs), including SOPs for services provided under patient group directions were in place and kept electronically. They 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 seen were clear about their roles. A medicine counter assistant said that she would refer all medicine sale requests for patients who were also taking prescribed medicines, to the pharmacist. She was aware of 'prescription only medicine' (POM) to 'pharmacy only medicine' (P) switches, such as sumatriptan and referred requests for these to the pharmacist. A request for Phenergan liquid for an eight-year old child was seen to be referred to the pharmacist.

The staff knew about the complaints procedure and reported that feedback on all concerns was encouraged. The pharmacy did an annual customer satisfaction survey but the staff seen were not aware of the results of the latest survey and they had not been uploaded onto the NHS website. This meant that the staff were unable to address any negative feedback in order to improve their services.

Public liability and professional indemnity insurance, provided by the National Pharmacy Association (NPA) and valid until 24 June 2020, was in place. The responsible pharmacist log, controlled drug (CD) records, including patient-returns, emergency supply records, specials records, fridge temperature

records and date checking records were in order. Private prescriptions records were kept electronically and all of those seen had no prescriber address details and only a few contained the prescriber's name. The superintendent gave assurances that the staff would be appropriately trained on these requirements.

An information governance procedure was in place and the staff had also 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 and had read the pharmacy's procedures on the safeguarding of both children and vulnerable adults. The regular pharmacists had completed the Centre for Pharmacy Postgraduate Education (CPPE) module on safeguarding. Local telephone numbers to escalate any concerns relating to both children and adults would be obtained electronically.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough staff to manage its workload safely. The team members are encouraged to keep their skills up to date but do this in their own time. However, those undergoing training are allocated time at work for their courses. But, the team members are not sure if there are any formal appraisals to identify any gaps in their skills and knowledge. This shows that communication from the management could be better.

Inspector's evidence

The pharmacy was a 100-hour pharmacy, in the centre of the town of Redditch and close to three doctor's surgeries. They mainly dispensed NHS prescriptions. Many domiciliary patients received their medicines in compliance aids.

The current staffing profile was: two pharmacists (working two shifts), one pre-registration student, four part-time NVQ2 qualified dispensers, one full-time NVQ2 trainee dispenser, one part-time NVQ2 trainee dispenser, one full-time medicine counter assistant, one full-time MCA trainee and two part-time delivery drivers. At the time of the inspection, there was just a pharmacist, a regular locum, a dispenser and a MCA working. They said that the pharmacy was busier in the afternoons and that there were better staffing levels then. The visit took place in the morning.

There was some flexibility for the part-time staff to cover any unplanned absences but the staff did have child-care commitments. Planned leave was booked well in advance and only one member of the dispensary staff could be off at one time. This time was generally covered by other staff members. Staff performance was monitored, reviewed and discussed informally throughout the year. The dispenser seen had only been employed for eight months and was not sure if the company did any formal performance appraisals. She had however had an induction period with one-to-one meetings on her progress.

The staff were encouraged with learning and development and completed e-Learning, but generally at home. Staff enrolled on accredited training courses were allocated time in work towards their courses, usually at the weekend. The pharmacist said that all learning was documented on his continuing professional development (CPD) records.

The staff knew how to raise a concern and reported that this was encouraged and acted on. A trainee dispenser had recently raised concerns about the tidiness of the shelves. Because of this, the staff were currently tidying and date checking all the shelves. There were monthly staff meetings and the staff seen said that they felt able to raise any issues. The pharmacist said that he was not set any formal targets or incentives.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy generally looks professional and is suitable for the services it offers. But, the work areas could be tidier. It signposts its consultation room, 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 generally presented a professional image. However, at the time of the visit the dispensing benches were cluttered and the shelves, where the stock was stored, could be tidier. The superintendent sent an email on 21 January 2020 giving assurances that the entire pharmacy would be tidied and de-cluttered by 27 January 2020. The premises were clean and well maintained.

There were two signposted consultation rooms but one of these was being used for the storage of unused items and invoices. It was locked. The other room, which was used as a consultation room, was small. It was not locked. The door contained a keyhole but this was unfinished and had no appropriate metal plate. The door to the room opened inwards and this further impacted on limited space. It also meant that access by the emergency services may be impeded if someone had to be placed in the recovery position on the floor. The regular pharmacists did offer flu vaccines and travel vaccines. The room was signposted. Conversations in the consultation room could not be overheard. The pharmacy 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 centigrade. 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 usually make sure that people have the information that they need to take their medicines properly. The pharmacy gets its medicines from appropriate sources. But, the pharmacy could have better procedures for the people who have their medicines in compliance aids.

Inspector's evidence

There was wheelchair access to the pharmacy and the consultation room with an automatic opening front door. The staff could access an electronic translation application for use by non-English speakers and they spoke the common Asian languages 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), Community Pharmacy Consultation Service (CPCS), supervised consumption of methadone and buprenorphine and seasonal flu vaccinations. The latter was also provided under a private scheme as were travel vaccines. The pharmacist seen was a locum and had not completed the required training to provide vaccination services.

Several substance misuse patients had their medicines supervised and several others took their medicines home. There was a dedicated folder for these patients where the prescriptions were kept. The telephone numbers of key workers were not available. The pharmacy was open for longer hours that the service provider and so these would be useful. Any concerns about these patients were recorded on their electronic prescription medication record (PMR). available. The patients were offered water or engaged in conversation to reduce the likelihood of diversion.

Many domiciliary patients received their medicines in compliance aids. These were assembled on a four-week rolling basis and evenly distributed throughout the week to manage the workload. There were no dedicated folders for these patients and there was no overall dispensing progress log. It was therefore difficult to see exactly where, in the dispensing cycle, all these patients were. Changes were recorded on the patient's PMR and said to be referred to at the checking stage. But, these were not recorded in the patient note section. The full PMR had to be examined and so there was no concise, chronological audit trail for easy reference. 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. But, one assembled compliance aid was seen to contain the unstable medicine, sodium valproate. No note had been made on the patient's PMR that the doctor had agreed that this should be de-blistered and placed in the compliance aid.

There was a good audit trail for all items ordered on behalf of patients but not always for all items dispensed by the pharmacy (see under principle 1). Interventions were seen to be recorded on the patient's prescription medication record. The pharmacist seen said that he routinely counselled patients prescribed high-risk drugs such as warfarin and lithium. INR levels were recorded. He also counselled patients prescribed amongst others, antibiotics, new drugs and any changes. CDs and insulin were not routinely checked with the patient on hand-out. All the staff seen were aware of the sodium valproate guidance regarding the pregnancy protection programme. They said that they had identified

three ‘at risk’ patients. These patients had been counselled and guidance cards were included with each prescription for them. All prescriptions containing potential drug interactions, changes in dose or new drugs were highlighted to the pharmacist. The pharmacist seen said that he had little time to do MURs or NMS reviews.

Medicines and medical devices were obtained from AAH, Alliance Healthcare, Lexon and Colorama. Some unlicenced medicines, such as folic acid 400mcg, were seen on the dispensary shelves. Specials were obtained from Sterling 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 a couple of patient-returned CDs but several out-of-date CDs. These were clearly labelled and separated from usable stock but were occupying valuable space in the cabinets. 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 no separate bin for cytotoxic and cytostatic substances but there was a list of such substances that should be treated as hazardous for waste purposes. The staff said that they would appropriately separate any substances on the list.

There was a procedure for dealing with concerns about medicines and medical devices. Drug alerts were received electronically, printed off and the stock checked. But, these were received by the regular employed pharmacist and not available in the pharmacy at the time of the visit or on the pharmacy’s computers. The regular pharmacist sent an email on 21 January 2020 stating that, any future drug alerts or other concerns would be uploaded onto the pharmacy’s computers with an appropriate audit trail of any required actions.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the appropriate equipment and facilities for the services it offers. 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 (5 and 10ml) and ISO stamped straight measures (10 to 100ml). There were tablet-counting triangles which 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.