General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Village Pharmacy, 44-46 Bramhall Lane South, Bramhall, Stockport, Greater Manchester, SK7 1AH

Pharmacy reference: 9010072

Type of pharmacy: Community

Date of inspection: 30/04/2019

Pharmacy context

This is a community pharmacy situated in a modern premises located on a shopping parade on a busy main road in a semi-rural residential area. It primarily prepares NHS prescription medicines, and provides prescription ordering and home delivery services. The pharmacy also supplies some weekly compliance packs, which are an aid to help people take their medicines and offers the NHS Medicine Use Reviews (MURs) service.

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 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 not all met	4.3	Standard not met	The pharmacy doesn't check the maximum and minimum temperatures of its refrigerated medicines. So it cannot be sure that these medicines are safe to supply.
		4.4	Standard not met	Staff do not know about the pharmacy's system for receiving alerts about defective medicines. So they may not always deal with these effectively.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance ✔ Standards met

Summary findings

The pharmacy has some written procedures to help make sure the team provides safe services. It has policies and procedures on protecting people's private information and team members receive training on these. The pharmacy team records and reviews its mistakes so that it can learn from them. But the records lack detail, so the team may miss some learning opportunities.

Inspector's evidence

The pharmacy had written procedures that were issued in March 2019 and were due for review in March 2021, that covered the principles of dispensing medicines safely. The responsible pharmacist (RP) who was a regular locum pharmacist and acted as the manager, explained that the superintendent pharmacist had drafted the procedures, but had not identified themselves as the author. There were no written procedures for arrangements when the RP was absent or changed, as required by law. And it did not have written procedures for dispensing medicines considered to be high risk, including anti-coagulants, methotrexate, lithium, insulin. So the team members may not always understand what to do in these circumstances.

The pharmacy had written procedures on recording and near misses that dispensary staff had signed to declare they had read and understood. The pharmacy team recorded mistakes they identified while dispensing medicines, and they said they also made a mental note of to be more vigilant. However, the team typically did not discuss in any detail or record why they had made each error. Although a section for recording why each near-miss occurred existed on the record form, written procedures suggested that it did not need to be recorded until the record was reviewed, which could be a month later. This made it harder for the team to identify trends and mitigate risks in the dispensing process.

The RP said that he and the team briefly reviewed near-miss records each month. Although they suspected that many of the near-misses were due to dispensers having to simultaneously cover the front counter and dispensary, this was consistently not recorded against each near-miss entry. And this suspected pattern was not reported to the superintendent pharmacist.

A dispenser and checker initialled dispensing labels to provide an audit trail, which assisted in investigating and managing risk in relation to near miss or dispensing incidents as well as providing some transparency around who was responsible for dispensing each medication.

The pharmacy team received positive feedback in the last patient satisfaction survey conducted between April 2017 and March 2018, and a publicly displayed notice explained how patients could make a complaint. The pharmacy had written procedures for handling dispensing errors, but it did not have a written complaint handling procedure. So, it was unclear how the pharmacy would address all concerns raised or obtain feedback that it could use to improve services.

The superintendent pharmacist said that the pharmacy had professional indemnity cover for the services it provided. The pharmacy maintained the records required by law for controlled drug (CD) transactions and medications dispensed against private prescriptions. It generally kept its electronic RP log in order, but pharmacists occasionally did not record the time they ceased to be the RP.

The pharmacy had detailed data protection policies and procedures including on maintaining patient

confidentiality and obtaining patient consent for services. Although the policies stated to obtaining explicit consent, it did not clarify how this should be done. The policies stated that data processes would be reviewed annually. However, there was no record of any being completed.

Nearly all the staff had read the data protection policies relevant to them. However, some of them had not read the confidentiality procedures, and the new trainee, who had been employed around two months, had not read any of them. The RP said that the trainee had been told about the importance of protecting patient confidentiality when they first started. Staff disposed of confidential waste securely.

The RP was level 2 safeguarding accredited, and a recently recruited dispenser had completed formal safeguarding training at their last pharmacy. All the staff had signed to declare they had read the pharmacy's written procedures on child protection. However, most of the staff were not level 1 safeguarding accredited, and a list of local referral agencies and their procedures were not available.

The delivery driver had a positive rapport with potentially vulnerable patients, which proved vital as staff recalled patients exhibiting confusion, which they reported to the pharmacist and GP. In some cases, this led to patients being more closely monitored, and reduced to weekly medication supplies. However, they had not kept records detailing each of these patient's care background, circumstances and arrangements. So, the team did not have easy access to this information.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy team members have the skills and experience necessary for their roles. But staffing levels mean the team sometimes struggles with the workload and the pharmacy does not always have an effective plan to cover staff absence. So people may not always receive their medicines on time. Team members do not have regular performance reviews or training plans. This could mean that gaps in their skills and knowledge are not identified and supported.

Inspector's evidence

The staff present were the responsible pharmacist (RP) who had been employed in a managerial role since December 2018, two full-time experienced dispensers, and a part-time Medicine Counter Assistant (MCA) employed around four years. The other staff employed included a part-time MCA who had been employed several years, a part-time trainee MCA and trainee dispenser employed around 2 years and a part-time trainee MCA employed around two months so in their three-month probationary period.

Staff said the superintendent was sometimes not very receptive to concerns. They told him about other staff members and staff shortages. But the superintendent put off addressing them. Staff said matters had improved under the RP. But the pharmacy still sometimes delayed dispensing medications.

There were regular and constant waves of three to five patients, who typically presented a prescription or wished to collect their repeat medication, waiting a significant time to be served. The MCA was working alone on the medicines counter, which was usual across the week, and so she constantly asked dispensers and the RP to assist in dealing with those waiting to be served.

The RP said that the open plan front counter/dispensary design meant the dispensary team was very visible to the public, so were frequently distracted mid-dispensing. Staff said that the queues were much longer for several hours during two or three afternoons each week. So, staff experienced sustained work-load pressures. Staff also said that they did not know whether a full-time MCA who suddenly left recently would be replaced. They said the second MCA had provided double front-counter cover, which meant dispensary staff were less likely to be distracted. Part-time staff could not increase their working hours to cover planned staff leave. So there were no effective plans to cover them.

Despite staff previously encouraging patients to use either the prescription ordering or Electronic Prescription Service (EPS) around a quarter of them chose to personally present their repeat prescriptions, which intensified work-load pressures. The MCA used the WHAMM model while questioning patients who requested over-the-counter sleep-aid medication, but occasionally asked them in the form of a leading question. So patients may get a medicine that is not appropriate for them.

The MCA checked and put away dispensary wholesale stock deliveries. However, this was contrary to GPhC requirements that state anyone receiving and storing pharmaceutical stock needs to take the relevant modules of the Level 2 certificate in pharmacy service skills. So, the MCA may not put medication in the correct location, which could lead to a mistake while dispensing them.

The trainee, who effectively started employment in July 2017, was not enrolled on an accreditation course until May 2018. Since the RP's recruitment, their training had progressed well, and were about

to complete the final module. Staff did not participate in an appraisal process, and there was no formal training plan or programme for accredited staff.

The pharmacy did not set any formal targets for the volume of services provided. The team obtained written patient consent for MURs, but only obtained verbal consent for the prescription ordering and Electronic Prescription Services. So, they may not be able to confirm if a patient agreed to a service if needed.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy's premises are a secure and professional environment for the services provided.

Inspector's evidence

The level of cleanliness was appropriate for the services provided. The premises had the space necessary to allow medicines to be dispensed safely for the scale of services provided. The consultation rooms offered the privacy necessary to enable confidential discussion, but their availability was not prominently advertised to the public.

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

Summary findings

The pharmacy generally manages its services safely. Team members offer some additional support to people on more complex medicines. The pharmacy gets its medicines from licensed suppliers. But it does not check the expiry dates or storage temperatures of its fridge medicines for long periods. And the team do not always adhere to the pharmacy's system for handling defective medicines. So it cannot properly demonstrate it manages medicines effectively.

Inspector's evidence

The pharmacy was open from Monday to Friday 9am to 6.30pm, and Saturday 9am to 5pm, meaning patients could access services across most of the week. The pharmacy had a step-free entrance with automatic doors. And the pharmacy team could see people entering the premises. So they could assist anyone having difficulty.

The pharmacy team asked patients to confirm the repeat medications they required four days before their prescription was due. This assisted in limiting medication wastage and patients receiving medication in a timely manner. The team also made corresponding records of requests, so they could deal with queries about them effectively.

The pharmacy team used disposable compliance pack trays to dispense medicines for patients who needed extra support taking their medicines safely. They labelled trays with descriptions of each medicine, which helped patients and carers to identify the individual medicines, reducing the risk of patients becoming confused about them.

The manager said that they routinely checked that patients prescribed anti-coagulants had their INR regularly monitored with each prescription presented. However, they did not make a corresponding record. They also counselled patients on their prescribed dose, and side-effects and interactions.

The manager said that they routinely counselled methotrexate patients on their prescribed dose, to take folic acid, and reminded them about potential side-effects and interactions with each prescription presented. However, the manager infrequently screened these patients for regular blood tests, as it would only queried annually during their MUR.

The manager also said that they checked lithium patients had a recent blood test with each prescription presented, but they did not make a corresponding record. However, the team confirmed that valproate patients had not been screened to identify those at teratogenic risk. And the pharmacy did not have the MHRA approved guidance and cards that should be given to valproate patients.

The pharmacy team used colour-coded baskets to prioritise prescription work-load and avoid each patient’s medicines becoming confused with others during the dispensing process.

The pharmacy obtained its medicines from a range of MHRA licensed pharmaceutical wholesalers. The superintendent said that the pharmacy was registered with the organisation responsible for establishing the UK medicines verification system to enable the Falsified Medicines Directive (FMD). They added that the pharmacy had the necessary software and hardware installed to be FMD compliant. However, the team did not scan medicines as they had not been trained. So, the pharmacy’s

system for adhering to the FMD was not operating, as required by law.

The pharmacy team typically only left a protruding flap on medication stock cartons to signify they were part-used, which risked patients receiving the incorrect medication quantity. Records indicated that the pharmacy team recently date-checked the medicine stock. However, the RP said that the pharmacy had no routine for date-checking stock prior to their arrival in December 2018, so they established a routine. The pharmacy's written procedures stated to date-check stock every three months. Several stock medicines selected at random were well within their use-by date.

The thermometer used in one of the medication refrigerators did not have a maximum and minimum temperature function. And staff only recorded the current temperature of the second medication refrigerator, as they did not know about obtaining the maximum and minimum temperature readings. Its current readings were within range for safe medicines storage. The team had not been monitoring the third refrigerator's temperatures since its installation around three weeks ago. Its current readings were in range for safe medicine storage.

The pharmacy team used an alpha-numerical system to store and retrieve bags of dispensed medication and the related prescription. So, the team could efficiently retrieve patients' medicines and prescription when they came to collect their medication. Staff also consistently asked recipients to confirm patient's address while handing out prescription medication. Records indicated that the pharmacy delivered medicines to patients safely and securely.

The team disposed of obsolete medicines appropriately in pharmaceutical waste bins segregated away from medicines stock, which reduced the risk of medicines not fit for purpose being supplied to patients. The pharmacy received electronic alerts about suspect medicines. However, the pharmacy did not have any records that indicated it had actioned them. And staff could not recall receiving or responding to alerts. This was because the team did not know the pharmacy received alerts or where to look for them.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs to provide the services it offers.

Inspector's evidence

The pharmacy team kept the dispensary sink clean. They also had hot and cold running water and an anti-bacterial hand-sanitiser. So, they had facilities to make sure they did not contaminate medicines they handled.

The team had a range of clean measures, including separate ones for methadone. So, they could accurately measure and give patients their prescribed volume of medicine. The team had access to the latest versions of the BNF and cBNF online. So, they could refer to the latest clinical information for patients.

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.