General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: The Village Pharmacy, 12 Guy Lane, Waverton, Chester, Cheshire, CH3 7NX

Pharmacy reference: 9010102

Type of pharmacy: Community

Date of inspection: 21/08/2019

Pharmacy context

This is a traditional community pharmacy on a small retail precinct in the centre of a rural village. NHS dispensing is the main activity, primarily for local people. The pharmacist reported that in the last few months there had been a significant increase in the number of prescriptions dispensed. The pharmacy also provides a number of other NHS services, sells a range of over-the-counter medicines, and has a post office which operates from one end of the pharmacy counter.

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

Members of the pharmacy team follow written instructions to help them work safely. But some of the written instructions need updating and they do not cover all of the pharmacy's services. So, team members may not always fully understand their responsibilities. The pharmacy team records things that go wrong so that it can learn from them. But it has only recorded a few incidents so there is little evidence that the pharmacy properly identifies risks. The team keeps the records that it needs to keep by law. And it knows what it needs to do to keep confidential information safe.

Inspector's evidence

The pharmacy had a set of electronic standard operating procedures (SOPs) in place that were dated to show they had been introduced in March 2017. The SOPs were listed on a paper record and staff had signed against each SOP to show that they had read and accepted it. The SOPs were listed only by number and there was no clear version control to provide assurance about which version had been read. The SOPs covered most of the pharmacy services but did not include all of the procedures specified in the responsible pharmacist regulations. For example, there was no specific SOP covering the circumstances in which non-pharmacist staff could give advice about medicines. A pre-registration pharmacist who had recently started working at the pharmacy had not yet signed any of the SOP records.

Monthly record sheets were available that had been used to record near miss dispensing incidents. One incident had been recorded in August and prior to that the last record had been made in May. Annual patient safety reports were available showing that typically two or three incidents a month were logged. The pharmacist said that only a few near misses were made and he believed that all incidents had been recorded. There were no learning points documented but the pharmacist was able to give several examples of things that had been done to manage risks that had been identified. He demonstrated that some medicines with similar names had been distinctly separated on the dispensary shelves to avoid picking errors. These included amitriptyline and amlodipine, and carbimazole and carbamazepine. Diabetic medicines were stored together in the dispensary to remind staff to take extra care when dispensing them.
There were no records of dispensing errors available. The pharmacist said he was not aware of any being made during the time he had worked at the pharmacy.

A responsible pharmacist (RP) notice was prominently displayed behind the medicines counter. The RP record was appropriately maintained and up to date. Staff roles and responsibilities were described in the SOPs. Dispensing labels were initialled by the dispenser, but the pharmacist admitted that he did not always initial labels when he did the final accuracy check. This meant there may not be a reliable audit trail in the event of any concerns or queries.

The pharmacy had a complaints procedure in place. Practice leaflets explained how people could make complaints or provide feedback. A current certificate of professional indemnity insurance was provided on request.

A controlled drugs (CD) register was appropriately maintained. Running balances were recorded and checked weekly. Patient returned CDs were recorded in a separate register and the records were up to date. Records of private prescriptions, emergency supplies and unlicensed specials were all in order.

A number of private prescription forms present appeared to contain a computer-generated signature. The pharmacist explained that the prescribing service normally sent the prescriptions as an attachment to an e-mail. He said he had contacted the prescriber who had assured him this met the requirements of an advanced electronic signature. However, this did not appear to be the case, which would mean the prescriptions were not legally valid. The pharmacist agreed to carry out additional checks before making any further supplies.

An information governance (IG) policy was available but the policy documents were a few years old. The pharmacist said the policy had been updated but he was unable to find a more recent version. Staff confirmed they had signed confidentiality agreements in their employment contracts. The dispenser explained that confidential waste was collected separately to be shredded. She said anything with names or addresses on would be treated as confidential.

A safeguarding policy was in place and the pharmacist confirmed he had completed level 2 training. The dispenser said if she had any concerns she would speak to the pharmacist in the first instance. A flow chart was available outlining the local reporting procedures and giving details of local contacts.

Principle 2 - Staffing ✔ Standards met

Summary findings

There are enough staff to safely manage the workload. They receive the training they need for the jobs they do. But members of the team have progressed slowly with their training. This means they need closer supervision, so the operation of the pharmacy may be less efficient.

Inspector's evidence

The superintendent pharmacist (SI) normally worked at the pharmacy and his occasional days off were covered by a locum pharmacist. The pharmacy also employed a pre-registration pharmacist who had only very recently started, a trainee pharmacy technician and an apprentice. The pharmacist's wife sometimes worked on the post office counter, but the pharmacist confirmed she did not sell medicines or work in the dispensary.

The apprentice was studying for a customer service qualification, which she had almost completed, but she had not received any formal pharmacy training. The pharmacist said the apprentice mainly worked on the post office counter but confirmed she also sold medicines, under his supervision, and did some tasks in the dispensary suck as putting away stock orders. He said he had delayed putting her on a dispenser's course because he did not want to overload her while she was doing her apprenticeship, but he immediately enrolled her as soon as the minimum training requirements were explained.

The trainee pharmacy technician had been employed at the pharmacy since 2016 and had been enrolled on the training course since 2017. The pharmacist said progression of her training had been delayed but he was aware that it needed to be completed within three years.

Both members of staff were provided with additional training material from 'Virtual Outcomes'. Certificates of completion were kept in a file. Recent subjects the apprentice had covered included smoking and preventing falls. Recent subjects the trainee technician had covered included asthma and bowel cancer.

During the inspection the pharmacy team were kept busy but managed the workload effectively. The pharmacist said the staffing level was normally adequate and said staff could be drawn from another branch to cover absences.

The dispenser gave examples of questions she would ask when selling medicines, based on the WWHAM sales protocol. She said she would refer to the pharmacist if unsure, for example if the customer was taking other medicines. She was aware that codeine products were liable to abuse and said she would refer to the pharmacist if there were repeat requests. Throughout the inspection the pharmacist was seen to intervene when queries arose and was heard giving advice to people about their treatment.

Members of the pharmacy team appeared to work well together and had a good rapport with customers. There was no whistleblowing policy was in place, but the dispenser said any concerns would normally be discussed with the SI.

The pharmacist said he did not set any specific performance targets for the pharmacy team.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is small, but it is well organised to make best use of the space that is available. It is generally clean and tidy, and it provides a suitable environment for healthcare.

Inspector's evidence

The pharmacy was situated in a small unit and the lack of space was challenging. But it was kept clean and tidy and was well organised to make best use of the space that was available. There was sufficient clear bench space to allow safe working, but a number of dispensing baskets were being stored on the floor while waiting to be checked. The pharmacist said there had been a significant increase in the volume of dispensing in recent months, so he was exploring the possibility of extending the dispensary. He had also purchased a nearby property, which he intended to use as a storage facility.

A consultation room was available for privacy. It was clean and tidy and suitably equipped. The availability of the room was advertised by a sign on the door.

The staff toilet was clean, but the area was also being used to store bins of waste medicines, which made access to the toilet and sink more difficult. It also contained empty plastic trays that were for use when medicines were dispensed in compliance aids. This was potentially unhygienic, so the pharmacist agreed to move them.

The dispensary was equipped with a sink with hot and cold water. All parts of the pharmacy were well lit.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides a range of services and they are easy to access. And it manages them to help make sure that people receive appropriate care and get the advice they need. It obtains medicines from licensed suppliers. And members of the pharmacy team carry out some checks to make sure the medicines are kept in good condition. But sometimes stock medicines are not properly labelled, so there may be more risk of things going wrong.

Inspector's evidence

The pharmacy entrance was level and suitable for wheelchairs. Practice leaflets contained details of the pharmacy's services and various other posters and leaflets contained further information about services and other healthcare topics. Staff were aware that they needed to signpost people wanting services that the pharmacy did not provide and said they would search the internet if necessary.

The pharmacy offered a delivery service. There were typically 10 to 15 deliveries a day, all of which were done by pharmacy staff. Deliveries were recorded on the delivery sheet to provide an audit trail and the recipient was asked to sign for deliveries that included controlled drugs. The pharmacist said they normally telephoned the patient prior to a delivery to make sure they would be home.

Dispensing baskets were used to keep individual prescriptions separate and avoid medicines being mixed up during dispensing. Dispensed medicines awaiting collection were bagged and kept with the prescription forms. There was no systems in place to highlight controlled drugs or high-risk medicines But the pharmacist said that medicines were always checked again against the prescription at the time they were handed out, so anything that needed counselling or further checks would be dealt with then. He said they would normally ask patients to confirm their INR when warfarin was supplied. But this was not recorded so the pharmacy may not be able to demonstrate what information was provided.

The pharmacist was aware of the risks associated with the use of valproate during pregnancy. He said he had checked the PMR and that the pharmacy did not currently have any patients who met the risk criteria. He knew that such patients should be counselled, and that warning stickers and educational material should be provided. However, he was unable to locate the educational material, so it may not be available to supply if the need arose.

The pharmacy supplied medicines in multi-compartment compliance aids (MDS) for about 60 patients. The trainee- technician said repeat prescriptions for MDS patients were always checked against the patient medication records (PMR) to make sure there hadn't been any changes. The PMR for MDS patients were annotated to show the usual dosage times so the staff would know which time slot to use when they assembled the tray. But times were not recorded if they were considered to be self-evident from the directions written on the prescription. So there was potential for inconsistency, which could cause confusion. A number of MDS trays were present awaiting supply and it was notable that some did not have packaging leaflets (PILs) included. There is a statutory requirement that these leaflets should always be provided to ensure patients have up to date information about their medicines.

The pharmacy obtained its medicines from licensed wholesalers and unlicensed specials were ordered

from a specials manufacturer. The pharmacy computer was fitted with scanners and there was an account with Securemed. The pharmacist said they were not currently able to decommission medicines to meet with the requirements of the falsified medicines directive because the computer software was not working properly. He said he had reported the fault to the software provider and was waiting for it to be resolved.

Stock medicines were stored in orderly fashion. The pharmacist said expiry date checks were carried out regularly, but they were not recorded. This meant the pharmacy was not able to demonstrate when checks had last been completed or provide assurance that all medicines had been checked. A random sample of stock was checked, and no expired medicines were found. However, there were some loose blister strips present that had been removed from their outer containers and some packs present that contained mixed batches of blister strips, for example, clarithromycin 500mg.

There was a medicines fridge in the dispensary. It was clean and tidy and equipped with a thermometer. The maximum and minimum temperatures were recorded daily and had remained within the required range. Controlled drugs were appropriately stored in a standard cupboard. Waste medicines were disposed of in dedicated bins that were kept in the toilet because of the lack of space elsewhere. The bins were collected periodically by a specialist waste contractor.

The pharmacy received drug alerts by e-mail from the NHS and had just registered to receive alerts from MHRA. The pharmacist said e-mails were checked daily by himself or his wife and records were kept to show that they had been actioned.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

Members of the pharmacy team have the equipment and facilities they need for the services they provide. And they use them in a way that protects privacy.

Inspector's evidence

The pharmacy had various reference books, including a recent edition of BNF, and the team could access the internet for general information. A stamped measuring cylinder was used to measure liquids.

Electrical equipment appeared to be in good working order. A blood pressure meter was in use. The machine was not dated but the pharmacist said it was only about a week old.

The dispensary was screened to provide privacy for the dispensing operation. The consultation room was used for services that required privacy and for confidential conversations and counselling. And there was a glass screen on the medicines counter to provide a degree of privacy for routine conversations. A cordless phone was available so that phone calls could be made without being overheard. Pharmacy computers were password protected and screens were positioned so that they were not visible to the public.

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.