General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Twilight Pharmacy, 309 Bolton Road, Birmingham, West Midlands, B10 0AU

Pharmacy reference: 9011280

Type of pharmacy: Community

Date of inspection: 24/06/2021

Pharmacy context

This community pharmacy is located inside a medical centre in a residential area of Sparkbrook, Birmingham. It is open extended hours including evenings and weekends. The pharmacy dispenses prescriptions and sells a range of over the counter medicines. It supplies some medicines in multi-compartment compliance aid packs to help make sure people take them at the right time. And it offers additional services including blood pressure monitoring, meningitis vaccine and flu vaccinations, during the relevant season. The inspection was completed during the COVID-19 pandemic.

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 identifies and manages risks adequately. It keeps people's private information safe and maintains the records it needs to by law. But records are not always clear, so the pharmacy may not easily be able to show what has happened. Pharmacy team members understand their roles and they know how to raise concerns to protect the wellbeing of vulnerable people.

Inspector's evidence

The pharmacy had a set of standard operating procedures (SOPs) covering operational tasks and activities. Some of the procedures had not been reviewed since 2017 and so they may not always reflect current practices in the pharmacy. Team members signed to confirm their acknowledgement and understanding, but there were some procedures that had not been signed by all team members. The dispenser confirmed that she had read all of the procedures and through discussion demonstrated a clear understanding of her role and responsibilities, including knowledge of the activities permissible in the absence of a responsible pharmacist (RP). The pharmacy had professional indemnity insurance provided by the National Pharmacy Association (NPA) and a displayed certificate was valid until the end of August 2021.

Pharmacy team members recorded the details of near misses on a paper log. But no records had been kept since February 2021 and some previous entries were incomplete and did not record details such as contributing factors or learning points. This may mean that some underlying patterns and trends go undetected and learning opportunities may be missed. The RP reported that all near misses were discussed at the time of the event and that changes were made in the dispensary as appropriate. This included separating medicines with similar packaging. The RP showed the inspector how a dispensing incident would be recorded using the patient medication record (PMR) system. The RP was aware of a previous dispensing incident several months ago but he could not locate a record of this on the day. He agreed to follow up with the colleague who had recorded the incident.

The pharmacy had made some changes in order to manage some of the risks during the ongoing COVID-19 pandemic. Public health notices encouraging people using the pharmacy to wear facemasks were displayed on the entrance door and a Perspex screen had been installed at the medicine counter. Pharmacy team members were not wearing face masks which may increase the risk of transmission, although all team members had been vaccinated.

The pharmacy had a complaint procedure, the details of which were displayed on a notice near to the consultation room. Most feedback was received verbally. The pharmacy had previously had a comments box on the medicine counter, but this had been removed during the COVID-19 pandemic.

The correct RP notice was displayed near to the medicine counter and the RP log was in order as were records for emergency supplies. Private prescription records were held electronically, and there were some examples seen where the details of the private prescriber were missing or had been recorded inaccurately. Records for the procurement of specials recorded patient details as an audit trail from

source to supply. The pharmacy kept controlled drug (CD) registers and a patient returned CD register was also in use.

The pharmacy was registered with the Information Commissioner's Office and its certificate of registration was displayed. Team members discussed the ways in which people's private information was kept safe. This included storing completed prescriptions out of public view and ensuring confidential information was not left on the medicine counter. Confidential waste was segregated and shredded on the premises. And team members held their own NHS smartcards which were secured when not in use.

The pharmacist had completed safeguarding training through the Centre for Pharmacy Postgraduate Education (CPPE) and discussed some of the concerns that might be identified. The pharmacy displayed the details of local safeguarding agencies in the dispensary. It also had a chaperone policy which was displayed near to the consultation room.

Principle 2 - Staffing ✔ Standards met

Summary findings

Pharmacy team members are appropriately trained for the work that they do. They feel comfortable to provide feedback on the pharmacy's services and they have access to some ongoing learning and development. But this is not always structured, so the pharmacy may not always be able to show how learning needs are identified and addressed.

Inspector's evidence

On the day of the inspection the RP was working alongside a qualified dispenser and a pre-registration pharmacist. Two work experience students were also present, and they were not seen to complete any dispensing activity during the inspection. The pharmacy also employed three other pharmacists and a pharmacy technician who were not present. The workload in the dispensary was manageable and the team were up to date with dispensing. Leave was planned in advance and where necessary cover was arranged with team members from a nearby branch of the pharmacy.

Pharmacy team members were appropriately trained for the roles in which they were working. The pre-registration pharmacist was usually based at the pharmacy's other branch but was providing cover on the day as the branches own pre-registration pharmacist was on study leave. The pre-registration pharmacist explained that he and his colleague had been enrolled on a pre-registration support programme through ProPharma. The course involved attending study days which covered clinical topics within the British National Formulary (BNF) as well completing calculations papers. The pre-registration pharmacist had regular reviews with his tutor to monitor progress throughout his training year. Other pharmacy team members completed some ad hoc training using pharmacy trade press materials, but no structured training time was provided. Team members received some informal feedback on their development.

Pharmacy team members discussed the sale of medication from the pharmacy. Each described the questions that they would ask to help ensure that sales were safe and appropriate. Both the pre-registration pharmacist and dispenser were aware of higher-risk medication which may be subject to abuse and concerns were referred to the pharmacist. The pharmacist was aware of issues with 'Purple Drank' in the local area and confirmed that the pharmacy did not sell codeine linctus. People requesting this via telephone were referred to their GP surgery.

The pharmacy team members worked together closely and were happy to provide feedback and raise concerns. They held regular informal team huddles to discuss any issues that arose. The pharmacy team members were comfortable to approach the RP and the other regular pharmacists, as well as the company directors who were easily contactable. There were no formal targets in place for pharmacy services.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean, tidy and well presented. It provides a suitable environment for the provision of healthcare services. And it has a consultation room which team members use to speak to people in private.

Inspector's evidence

The pharmacy was completed to a high standard and portrayed a professional appearance. There was adequate lighting throughout and the temperature was suitable for the storage of medicines. The pharmacy was clean and tidy, with pharmacy team members completing cleaning duties throughout the working day.

The retail area to the front of the pharmacy stocked a range of over-the-counter medicines and pharmacy only medicines were secured behind the medicine counter. The retail area also stocked a range of chocolate, crisps and carbonated drinks which are not in keeping with a healthcare-based business. The pharmacy had a consultation room, which was equipped with a desk and seating to facilitate private and confidential discussions.

The dispensary was a suitable size to manage the current dispensing workload. There was a defined workflow through the dispensary and the work benches were clear of unnecessary clutter. Medicines were stored on large shelving units and the floorspace was free from obstructions.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy sources and stores its medicines appropriately and team members complete some checks to help make sure that medicines are fit for supply. The pharmacy's services are accessible and generally well organised. But the pharmacy could do more to help make sure that people using compliance aid packs have all of the information they need to take their medicines safely.

Inspector's evidence

The pharmacy had step-free access from the entrance to the medical centre and it was clearly signposted from the car park. The pharmacy opening hours were listed on the entrance door and the pharmacy had some health promotional materials displayed. Team members had access to NHS resources to help signpost people to other appropriate services, but records of signposting were not always kept.

Prescriptions were dispensed using baskets in order to keep them separate and reduce the risk of medicines being mixed up. The pharmacy had a patient prescribed warfarin. The RP said that discussion regarding monitoring arrangements were discussed verbally by telephone, but a record of this was not kept. Other high-risk medications were not routinely identified for additional counselling. The RP was aware of the risks of the use of valproate-based medicines in people who may become pregnant. He discussed the steps that he would take to ensure that any supplies were safe and appropriate but was unable to locate the necessary patient alert cards on the day. The RP confirmed that the pharmacy did not currently have any people prescribed a valproate-based medicine who was within the 'at risk' criteria and he agreed to follow-up on sourcing the necessary warning materials post-inspection.

The pharmacy offered a repeat prescription service to two local GP surgeries. Other nearby surgeries requiring patients to request their medicines directly. The pharmacy used the computer system to maintain an audit trail and help identify unreturned prescription requests. The pharmacy also operated a delivery service. The RP confirmed that checks of name and addresses were completed at the time of delivery, but delivery records were not available for review during the inspection.

The pharmacy supplied a large number of people with medicines in multi-compartment compliance aid packs. Medicines for people using compliance aid packs were ordered in the same manner as repeat prescription patients and a master record of their medications was held, along with the details of any changes. Completed compliance aid packs seen during the inspection did not contain an audit trail to identify those involved in the dispensing process. The backing sheet also did not contain BNF warning labels and patient leaflets were not supplied, so people may not always get all the information they need about their medicines.

The pharmacy sourced its medicines from a reputable wholesaler and specials from a licensed manufacturer. Stock medicines were arranged in an organised manner and in the original packaging provided by the manufacturer. The pharmacy completed date checking and they kept some records of short-dated items, which were then removed from the shelves at the end of each month. No expired

medicines were identified during random checks of the dispensary shelves. Obsolete and returned medicines were disposed of in suitable medicines waste bins.

The pharmacy fridge was fitted with a maximum/minimum thermometer and the temperature was checked and recorded each day. The fridge was within the recommended temperature range during the inspection. CDs were stored appropriately, and random balance checks were found to be correct.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs to provide its services. Team members use the equipment in a way that protects people's privacy.

Inspector's evidence

The pharmacy had access to paper-based reference sources including the British National Formulary (BNF). Further information sources were available via the internet. The pharmacy had clean tablet counters for loose tablets and a range of approved measures for measuring liquids. The measures were clearly marked for different uses.

Electrical equipment was in working order and had been PAT tested. The computer systems were password protected and screens were positioned out of public view. The pharmacy had a cordless phone to enable conversations to take place in private. Additional equipment had also been sourced in response to the COVID-19 pandemic. This included items of personal protective equipment (PPE) such as face masks and a removable barrier which could restrict access to certain parts of the retail area.

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.