General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Allied Pharmacy - Crosby Road, 75-79 Crosby Road North, Waterloo, Liverpool, Merseyside, L22 4QD

Pharmacy reference: 9011922

Type of pharmacy: Community

Date of inspection: 17/05/2023

Pharmacy context

This is a community pharmacy situated on a major road in the town of Crosby, in Merseyside. The pharmacy dispenses NHS prescriptions, private prescriptions and sells over-the-counter medicines. It also provides a range of services including COVID vaccinations, a minor ailment service and substance misuse supplies. The pharmacy supplies medicines in multi-compartment compliance aids for some people to help them take the medicines at the right time.

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 not all met	1.6	Standard not met	The pharmacy's controlled drug registers are inaccurate, and responsible pharmacist records are incomplete. So the pharmacy is not able to show it is keeping the records it needs to, in order to operate safely and effectively.
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 not all met**

Summary findings

The pharmacy team follows written procedures, and this helps to maintain the safety and effectiveness of the pharmacy's services. Members of the team take some steps to learn from things that go wrong. But they do not review the records of their mistakes. So some learning opportunities may be missed. And some of the pharmacy's records are incomplete or inaccurate, so it cannot always show that it is operating safely and effectively.

Inspector's evidence

There was a set of standard operating procedures (SOPs) which had been recently updated by the head office. Members of the pharmacy team confirmed that they had read the SOPs. But they had not signed the training sheets. So it was not clear when the SOPs had been read or whether they had been fully understood.

The pharmacy had a procedure in place to record and investigate any dispensing errors. A pharmacy technician, who worked as an accuracy checker (ACPT), explained that when she identified any mistakes, she discussed them with members of the team so that they could learn from them. She also described how she would record the details in a near miss log. But she was not able to locate this, so could not show what had been recorded. She admitted they did not review the records to help identify trends. Members of the team gave examples of medicines things they had done in the past to avoid errors being repeated, such as separating stock medicines with similar names to avoid picking errors. But they were not able to provide any recent examples.

Roles and responsibilities of the pharmacy team were described in individual SOPs. A dispenser was able to explain what her responsibilities were and was clear about the tasks which could or could not be conducted during the absence of a pharmacist. The pharmacy had a complaints procedure, but it was not advertised so people using the pharmacy may not know how they can raise concerns or give feedback. A current certificate of professional indemnity insurance was on display.

There was no responsible pharmacist (RP) notice on display to inform people who the RP was. An RP record was maintained but there were seven missing entries from the past seven weeks. Records of private prescriptions appeared to be in order. Controlled drugs (CDs) registers were electronically maintained with running balances recorded. Two random samples were checked and, in both cases, the running balances recorded in the registers were found to be incorrect. A separate register was used to record any patient returned CDs.

An information governance (IG) policy was available. But members of the team had not signed the training record to show they fully understood what was expected of them. When questioned, team members were able to explain how they would protect people's information. Such as segregating confidential waste into a separate waste bag for removal by an authorised waste carrier. But there was no information on display to tell people how the pharmacy handled personal information. Safeguarding procedures were included in the SOPs and the pharmacy team had completed safeguarding training. The pharmacist had completed level 2 safeguarding training. Contact details for the local safeguarding board were available. A dispenser said she would initially report any concerns to the pharmacist on duty.

Principle 2 - Staffing ✔ Standards met

Summary findings

There are enough team members to manage the pharmacy's workload and they are appropriately trained for the jobs they do. Members of the pharmacy team complete some additional training to help them keep their knowledge up to date.

Inspector's evidence

The pharmacy team included a pharmacist manager, a trainee pharmacist, two pharmacy technicians, one of whom was trained to accuracy check, three dispensers and a trainee medicine counter assistant (MCA). All members of the pharmacy team were appropriately trained or on accredited training programmes. The volume of work appeared to be managed. Staffing levels were maintained by part-time staff and a staggered holiday system. Two members of relief staff were present at the time of inspection.

Members of the pharmacy team completed some additional training, for example they had recently completed a training pack about cancer awareness. But further training was not provided in a structured or consistent manner. So learning needs may not always be fully addressed. A dispenser gave examples of how she would sell a pharmacy only medicine using the WWHAM questioning technique, refuse sales of medicines she felt were inappropriate, and refer people to the pharmacist if needed. The pharmacist was seen to exercise his profession judgement, and this was respected by members of the team.

A dispenser who was currently training as an accuracy checker felt she received a good level of support from the pharmacist and pharmacy team. Members of the team were aware of the whistleblowing policy and said that they would be comfortable reporting any concerns to the head office. There were no targets set for professional services.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are suitable for the services provided. Consultation rooms are available to enable private conversations.

Inspector's evidence

The pharmacy had been recently refurbished. It was generally clean and tidy, and appeared adequately maintained. The size of the dispensary was sufficient for the workload and access to it was restricted by a gate. Customers were not able to view any patient sensitive information due to the position of the dispensary. The temperature was controlled using air conditioning. Lighting was sufficient. Members of the team had access to a kitchenette area and WC facilities.

Two consultation rooms were available. The space was clutter free with a desk, seating, adequate lighting, and a wash basin. The patient entrance to the consultation rooms were clearly signposted and indicated if the rooms were engaged or available.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's services are easy to access. And it manages and provides them safely. It gets its medicines from recognised sources and stores them appropriately. Members of the pharmacy team do not always know when they are handing out higher-risk medicines. So they might not always be able to give people advice about taking them or make extra checks to be sure they are still suitable.

Inspector's evidence

Access to the pharmacy was via a single door that was suitable for wheelchair users. There was also wheelchair access to one of the consultation rooms. The pharmacy's services and opening hours were displayed. But there was little information on display about other healthcare topics.

The pharmacy team initialled dispensed by and checked by boxes on dispensing labels to provide an audit trail. They used dispensing baskets to separate individual patients' prescriptions to avoid items being mixed up. The baskets were colour coded to help prioritise dispensing. Owing slips were used to provide an audit trail if the full quantity could not be immediately supplied. The pharmacist performed a clinical check of all prescriptions and then signed the prescription form to indicate this had been completed. When this had been done an accuracy checker was able to perform the final accuracy check.

Dispensed medicines awaiting collection were kept on a shelf using a numerical retrieval system. Prescription forms were retained, and stickers were used to clearly identify when fridge or CD safe storage items needed to be added. Members of the team were seen to confirm the patient's name and address when medicines were handed out. But schedule 3 and 4 CDs were not routinely highlighted to remind members of the team to check that the prescription was still valid at the time of supply. And they also did not routinely highlight any high-risk medicines (such as warfarin, lithium, and methotrexate) in order to provide counselling. Members of the team were aware of the risks associated with the use of valproate during pregnancy. Educational material was available to hand out when the medicines were supplied. The pharmacist said he had spoken to patients who were at risk to make sure they were aware of the pregnancy prevention programme. And this was recorded on their PMR.

Some medicines were dispensed in multi-compartment compliance aids. Before a person was started on a compliance aid the pharmacy team completed an assessment of their suitability. A record sheet was kept for each patient, containing details about their current medication. Any medication changes were confirmed with the GP surgery before the record sheet was amended. Hospital discharge information was sought, and previous records were retained for future reference. Disposable equipment was used to provide the service, and the compliance aids were labelled with medication descriptions and a dispensing check audit trail. Patient information leaflets (PILs) were routinely supplied.

The pharmacy had a delivery service. Deliveries were segregated after their accuracy check and logged onto an electronic device which was then used to keep a record of delivery. Unsuccessful deliveries were returned to the pharmacy and a card was posted through the letterbox indicating the pharmacy had attempted a delivery.

A covid vaccination service had been commissioned by the local area team. Vaccines were provided under the national protocol. The RP acted as the clinical supervisor responsible for the provision of the service. A folder contained the necessary paperwork, including a copy of the national protocol. There was a process for vaccinators to escalate any questions or concerns they had to the pharmacist.

Medicines were obtained from licensed wholesalers, and any unlicensed medicines were sourced from a specials manufacturer. Members of the team explained that they checked the expiry dates of stock medicines as and when they could but did not keep records. This meant the team could not demonstrate when stock had last been checked and there was a risk of some medicines being overlooked. A random sample of medicines were spot-checked, and no out-of-date stock was found. Liquid medication had the date of opening written on. Controlled drugs were stored appropriately in the CD cabinet, with clear segregation between current stock, patient returns and out of date stock. CD denaturing kits were available for use. There were clean medicines fridges, each equipped with a thermometer. Records were kept when the temperatures were checked, this was normally done daily but there were some occasional gaps in the records. So the pharmacy may not notice straight away if the fridge malfunctioned. Patient returned medication was disposed of in designated bins located away from the dispensary. Drug alerts were received by email from the MHRA. Alerts were printed, action taken was written on, initialled and signed before being filed in a folder.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

Members of the pharmacy team have access to the equipment they need for the services they provide. And they maintain the equipment so that it is safe to use.

Inspector's evidence

Team members had access to the internet for general information. This included access to the BNF, BNFc and Drug Tariff resources. All electrical equipment appeared to be in working order. There was a selection of liquid measures with British Standard and Crown marks. Separate measures were designated and used for methadone. The pharmacy also had counting triangles for counting loose tablets including a designated tablet triangle for cytotoxic medication. Equipment was kept clean.

Computers were password protected and screens were positioned so that they weren't visible from the public areas of the pharmacy. A cordless phone was available in the pharmacy which allowed members of the team to move to a private area if the phone call warranted privacy. The consultation room was used appropriately. Patients were offered its use when requesting advice or when counselling was required.

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.