General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Touchwood Pharmacy, 47 - 48 Birchills Street, Walsall, West Midlands, WS2 8NG

Pharmacy reference: 9012023

Type of pharmacy: Community

Date of inspection: 13/09/2023

Pharmacy context

This community pharmacy is located in the Birchills area of Walsall, which is close to the town centre. People using the pharmacy are from the local community and a home delivery service is available. The pharmacy dispenses NHS prescriptions, and it offers some NHS funded services. And it acts as a 'hub' and dispenses medicines in multi-compartment compliance packs for collection or onward supply from other pharmacies within the same legal entity.

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 manages the risks associated with its services to make sure people receive appropriate care. Members of the pharmacy team follow written procedures to make sure they work safely. They discuss their mistakes so that they can learn from them, and they make changes to stop the same sort of mistakes from happening again. The pharmacy team keeps people's information safe and team members understand their role in supporting vulnerable people.

Inspector's evidence

The pharmacy was well-established and had been operating for many years. It had extended into the vacant unit next door in January 2023. The new part of the premises had been refitted and a wall between the two units had been knocked down to create an internal walkway between the old and new parts. A multi-compartment compliance pack dispensing robot had been installed into the new part of the premises and this pharmacy was a dispensing 'hub' for 19 'spoke' pharmacies. There was a temporary pharmacy manager for the hub and one of the company directors was in regular contact with the team to provide support as the process was relatively new.

The pharmacy was part of a chain of pharmacies located in the West Midlands and the south of England. A range of corporate standard operating procedures (SOPs) were available which covered the activities of the pharmacy and the services provided. SOPs were held electronically, and the pharmacy team members accessed their personal SOP record using their smart phone device or the pharmacy computers. Different SOPs and training modules were uploaded to the team members training library dependent on their job role. Each SOP was marked by the team member to confirm that they had read it. Head office sent pharmacist managers a list of the outstanding SOP training for their pharmacy so they could address this with individual team members. There were several newer members of the team who had very recently started their apprenticeships and their SOP training was ongoing. The SOPs for the compliance pack dispensing hub were available in a folder in the dispensary. The pharmacy team members that carried out hub activities had read and signed these SOPs in addition to the electronic SOPs. Roles and responsibilities were highlighted within the SOPs.

Many of the pharmacy's processes and records were managed electronically which meant that records were easily accessible, and the computer system had alerts to remind the pharmacy team to do certain tasks. Near miss records were held on this system and a 'dashboard' summarised the number of near misses recorded. There were Quick Response (QR) codes displayed in the dispensary so that the dispensers could scan the QR code using their mobile phone and enter the details of the near miss. There were two recording profiles used at the pharmacy: one for the dispensary and one for the compliance pack dispensing hub.

There was a process for learning from near misses involving the 'hub and spoke' model which included recording the mistake on the near miss log and informing a company director so that a pharmacy professional had oversight of how the system was working and they could address any process issues, or issues at other pharmacies. The procedure for correcting a mistake had changed over the past six-months as the company director and pharmacy team were conscious that they did not want to create additional workload or interruptions for the spoke pharmacy. They had continued to inform the spoke

pharmacy so that they were aware and could use it a learning opportunity, but the hub pharmacy made the changes themselves.

The pharmacy team gave some examples of different types of mistakes and demonstrated some examples of how processes had been adapted to try and avoid the same mistake happening again. The near miss log was reviewed by a pharmacy team member monthly and the learnings were recorded so they could be shared with team members who were not present. There had been some changes to the pharmacy team over the past few months and some of the tasks that had been carried out by one of the team members who had left had not been picked up when they had left. The pharmacist manager and a dispenser said that they would address this and re-allocate these tasks. The outcome of the review was recorded electronically and used to create an annual patient safety review for the NHS Pharmacy Quality Scheme (PQS) report. Dispensing errors were recorded, reviewed, and reported to head office using the electronic system. Head office reviewed the error and contacted the pharmacist manager if anything else was required.

Members of the pharmacy team were knowledgeable about their roles and discussed these during the inspection. A dispensing assistant answered hypothetical questions related to high-risk medicine sales correctly.

The pharmacy's complaints process was explained in the SOPs. People could give feedback to the pharmacy team in several different ways; verbal, written and online. The complaints policy was also outlined on the company's website and included the contact details for head office and the superintendent. The pharmacy team tried to resolve issues that were within their control and would involve head office if they could not reach a solution.

The pharmacy had up-to-date professional indemnity insurance. The responsible pharmacist (RP) notice was clearly displayed, and the RP log met requirements. Controlled drug (CD) registers were in order and two random balance checks matched the balances recorded in the register.

Confidential waste was stored separately from general waste and sent offsite to be destroyed securely. Some of the pharmacy team had their own NHS Smartcards and confirmed that they did not share their passcodes. The pharmacy professionals had completed the Centre for Pharmacy Postgraduate Training (CPPE) on safeguarding. The pharmacy team understood what safeguarding meant and were aware of their responsibilities. A delivery driver gave examples of types of concerns that she may come across when delivering prescriptions, and what action that she would take.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough suitably trained team members to manage the workload and the services that it provides. The team members plan absences in advance, so they always have enough cover to manage the workload. The team members work well together in a supportive environment, and they can raise concerns and make suggestions. Ongoing training is provided so that they stay up to date.

Inspector's evidence

The pharmacy team comprised of a pharmacist manager, a hub manager (dispensing assistant), an accuracy checking technician, two dispensing assistants, a trainee dispensing assistant, three apprentices, and two home delivery drivers. A dispensing assistant was working towards an accuracy checking dispensing assistant qualification. All of the team members had completed or were working towards a suitable qualification. Holidays were discussed with other team members to ensure no-one else had already booked the same week and requests were sent to head office for final approval. Cover was provided by other staff members as required. Pharmacy team members completed ongoing training and training needs were identified to align with new services, seasonal events and the NHS Pharmacy Quality Scheme (PQS).

Experienced staff members from other pharmacies had been transferred to the pharmacy to work in the hub. The team explained that they thought it was important that the hub was run by staff that had experience as they were able to use their professional judgement to identify any potential issues and address these promptly. They gave some examples of how they had made suggestions about how the process could be amended and improved, and how the company director had been open to these suggestions and had made changes as a result.

A review of the staffing requirements had been carried out and there was a vacancy for an accuracy checking technician to work in the hub. Three new apprentices had recently started at the pharmacy and a trainee pharmacist was due to start next month. The new members of the team were allocated certain tasks and worked alongside the more experienced team members so that they could ask questions and be given on the job training.

The pharmacy team worked well together during the inspection and were observed helping each other and moving from their main duties to help with more urgent tasks when required. Tasks were delegated to different members of the team so that the workload was managed. The pharmacy staff said that they could raise any concerns or suggestions with the pharmacist manager and felt that they were responsive to feedback. Team members said that they would speak to other members of the team, contact head office or GPhC if they ever felt unable to raise an issue internally. The pharmacist manager was observed making himself available throughout the inspection to discuss queries with people and giving advice when he handed out prescriptions, or with people on the telephone.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy provides a safe, secure and professional environment for people to receive healthcare services. The pharmacy team uses a consultation room for some services and if people want to have a conversation in private.

Inspector's evidence

The premises were smart in appearance and appeared to be well maintained. Any maintenance issues were reported to head office. The dispensary was an adequate size for the services provided and an efficient workflow was in place. Dispensing and checking activities took place on separate areas of the worktops and a different part of the premises was used for dispensing compliance packs. There were multiple stockrooms upstairs, an office and staff facilities. The old premises had been refitted and extended over the years and had outgrown the space available, which was the reason for the expansion into the unit next door.

A private soundproof consultation room was signposted for people using the pharmacy. The consultation room was professional in appearance. The door to the consultation room remained closed when not in use to prevent unauthorised access.

The pharmacy had an air conditioning system which heated and cooled the pharmacy. The system regulated the air temperature to ensure it was within a suitable and comfortable range. The dispensary was clean and tidy with no slip or trip hazards. The sinks in the dispensary and staff areas had hot and cold running water, hand towels and hand soap available. Cleaning was carried out by the pharmacy team and there was a cleaning rota. Prepared medicines were held securely within the pharmacy premises and pharmacy medicines were stored behind the medicines counter.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy offers a range of healthcare services which are easy for people to access. It manages its services and supplies medicines safely. But the pharmacy does not routinely supply patient leaflets with compliance packs, which means people might not have access to all the information they need about their medicines. The pharmacy obtains its medicines from licensed suppliers, and stores them securely and at the correct temperature, so they are safe to use.

Inspector's evidence

The pharmacy entrance had a small step up from the pavement. A home delivery service was offered to people who could not access the pharmacy. The pharmacy staff referred people to local services when necessary. They used local knowledge and the internet to support signposting. Pharmacy staff were observed speaking to patients in different languages during the inspection. Staff could speak to patients in English, Punjabi, Mirpuri, and Urdu. They used Google Translate when communicating in other languages. The pharmacy team had a good rapport with people using the pharmacy and offered medicines information and other advice throughout the inspection.

Items were dispensed into baskets to ensure prescriptions were not mixed up together. Different coloured baskets were used to prioritise certain prescriptions. Staff signed the dispensed and checked boxes on medicine labels, so there was a dispensing audit trail for prescriptions.

The team were aware of the risks associated with the use of valproate during pregnancy, and the need for additional counselling. Patient cards and counselling materials were available. Valproate was dispensed into some compliance packs. The RP explained that he assumed that the special warning sticker was attached to the compliance pack at the spoke pharmacy and that the required counselling was also done by the spoke pharmacy. The RP had not seen the SOPs or discussed this with any pharmacists at the spoke pharmacies, so it was unclear which pharmacy was responsible for doing this. The RP was going to ask for a copy of the spoke SOPs following the inspection.

The pharmacy dispensed compliance pack prescriptions for 19 other Touchwood Pharmacies. These compliance packs were supplied to the pharmacies for onward supply. There was a carefully planned schedule for dispensing to ensure there was enough capacity for the robot and the pharmacy team operating it. The spoke pharmacy entered the details of the prescriptions onto their computer system, they made any interventions and the pharmacist carried out a clinical check. They then submitted a batch of prescriptions to the hub for assembly. The hub then downloaded the information, printed the labels for the packs and the robot dispensed the medication. The team at the hub checked the backing sheet to ensure that all of the required information had been entered and looked for any anomalies. An accuracy check against the labels took place within the hub pharmacy before the completed packs were sent to he spoke pharmacy. The spoke pharmacy then carried out an additional accuracy check using the prescriptions before packs were supplied.

The stock for the robot was de-blistered and placed into canisters. Each canister contained the same batch number and expiry date so that there were no mixed batches. Barcodes were used to manage the stock and the barcodes from the canister and the stock boxes were scanned before it was put into the

robot as an accuracy check. A dispensing assistant kept additional records of when the stock had been removed from its original packaging and which members of the team had been involved in the process. A pharmacist or experienced member of the team performed a second check before the medicines were de-blistered. The pharmacist manager was unsure whether any risk assessments had been carried out to assess the suitability of medicines that were being de-blistered. A sample of dispensed compliance packs were seen to have been labelled with descriptions or photographs of medication. Patient information leaflets were not routinely supplied so people might not have access to this additional information.

The computer system that accompanied the robot had photographs of some medications which were printed onto labels attached to the packs so that people could differentiate between the different medicines. If the computer system did not have a photograph of the medicine, the dispensing assistant added a written description of the medication for the label. The computer system used QR and barcode technology as an additional accuracy check throughout the process. Each of the compliance packs had a barcode assigned to it which was scanned throughout the dispensing process. The medicines placed into the robot were used quickly, however, the robot did track expiry dates and had the ability to alert the team if there were any short dated batches in the canisters.

Date checking took place regularly and no out of date medication was found during the inspection. Medicines were stored in an organised manner on the dispensary shelves. All medicines were observed being stored in their original packaging. Split liquid medicines with limited stability once they were opened were marked with a date of opening. Patient returned medicines were stored separately from stock medicines in a designated area. Medicines were obtained from a range of licenced wholesalers. Drug recalls were received by email and marked when they were actioned.

The CD cabinet was secure and a suitable size for the amount of stock held. Medicines were stored in an organised manner inside. The pharmacy fridge was within the required temperature range of 2°C and 8°Celsius and the pharmacist manager said that he checked the temperature every morning but did not record it. There was a facility to record the fridge temperature on the pharmacy's computer, but they did not use it. This was one of the processes that had been overlooked since a team member had left the pharmacy and the RP agreed to ensure it was recorded.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide its services safely. The robot is serviced regularly and there is a contingency plan in place in case the equipment fails.

Inspector's evidence

The pharmacy had access to a range of reference sources, including the including the British National Formulary (BNF) and the children's BNF. Internet access was available. Patient records were stored electronically and there were enough terminals for the workload currently undertaken. A range of clean, crown stamped measures were available. Counting triangles were used and there was a separate, marked triangle used for cytotoxic medicines. Computer Screens were not visible to the public as they were excluded from the dispensary.

A dispensing robot was used to assemble multi-compartment compliance packs. The team members that operated the robot had received training on how to use it. The robot was serviced regularly, and some staff members had been trained to undertake cleaning and minor maintenance. The team had telephone numbers for technical support if they could not resolve a problem. There was a webcam available so that the technical support team could be shown error messages or ask to see certain parts of the robot. The team could resort to manual dispensing if technical problems with the robot could not be resolved.

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.