General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: West Street Pharmacy, 8 - 10 West Street, DUNSTABLE, Bedfordshire, LU6 1SX

Pharmacy reference: 1028832

Type of pharmacy: Community

Date of inspection: 20/08/2020

Pharmacy context

The pharmacy is in the main shopping area of the town. It provides NHS and private prescription dispensing mainly to local residents. The team also dispenses medicines in multi-compartment compliance packs for a lot of people. And it provides supervised consumption for people being treated by the local drug and alcohol team. The inspection was undertaken 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

Pharmacy team members usually work to professional standards and try to identify and manage risks effectively. They record or discuss mistakes they make during the dispensing process with the regular pharmacist. And they try to learn from these to avoid problems being repeated. Its team members understand how they can help to protect the welfare of vulnerable people. The pharmacy team members keep people's private information safe. The pharmacy has assessed the risks associated with COVID-19 and made improvements to help reduce the risks in the pharmacy.

Inspector's evidence

The pharmacy had standard operating procedures (SOPs) but some of these were due to be reviewed. Team roles were defined within the SOPs and team members had read and signed SOPs relevant to their roles. The superintendent pharmacist had issued the team with guidance for maintaining social distance during the pandemic. The team had been routinely ensuring infection control measures were in place. Team members had been provided personal protective equipment (PPE). The responsible pharmacist (RP) explained that the necessary risk assessments to help manage COVID-19 had been completed and this included occupational ones for the staff. Team members were observed to maintain distance from each other whilst working. The pharmacist was reminded of the need to report any relevant COVID-19 cases in the team to the Health and Safety Executive (HSE). The pharmacy team members had discussed how to make the pharmacy more accessible to people, especially during poor weather. They were proposing to introduce a one-way system into the shop, so that they could give better access.

The pharmacy recorded dispensing mistakes which were identified before the medicine was handed out (near misses) and those where the medicine was handed to a person (dispensing errors). Near misses were discussed with the team as they occurred. As a result of a previous discussion about a near miss, amitriptyline and amlodipine had been moved on the shelves to avoid picking errors.

The correct RP notice was displayed. The team members were aware of the tasks that could and could not be carried out in the absence of the RP. The pharmacy had current professional indemnity and public liability insurance. The pharmacy had a complaints procedure and also completed an annual patient satisfaction survey. People were referred to the pharmacy owner if they had a complaint. The pharmacy had received positive feedback about the delivery service during the pandemic as they had increased the number of deliveries and the numbers did not seem to be decreasing, despite the opening-up of lockdown.The pharmacist reported that he did balance checks of the controlled drugs when he dispensed them, and on a regular basis for all of these medicines.

Confidential material was destroyed using a shredder. The pharmacist and registered pharmacy technician had done appropriate safeguarding training for the protection of vulnerable people and had briefed the team. The pharmacy had details available for the local safeguarding boards for use in an emergency.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough team members to provide its services, and they work effectively together and are supportive of one another. They have the appropriate skills, qualifications and training to deliver services safely and effectively. Team members are given some ongoing training. But this is not very structured, and they are not given time set aside for training. This could make it harder for them to keep their knowledge and skills up to date.

Inspector's evidence

At the time of the inspection the pharmacy team comprised of the responsible pharmacist, a registered pharmacy technician and two counter assistants. All the staff had appropriate training for their roles. The counter staff counselled people on the use of over-the-counter medicines and asked appropriate questions before recommending treatment. They were aware of the maximum quantities of some medicines that could be sold over the counter. The dispensary was organised and the dispensing and other tasks were managed by the team.

Changes had been made to the process of handing out prescriptions during the pandemic.
These included using hand gel before and after handing the medication to people. And only obtaining signatures at the back of the prescriptions when required.

Team members said that they felt able to discuss any issues or raise concerns with the owner and the regular pharmacist who gave team members feedback as well as providing feedback to the owner. The superintendent pharmacist came to visit the pharmacy regularly to check how the team were doing. He had also taken over the delivery service, until another driver could be employed. The team did not hold formal meetings but discussed things as they arose.

There was no formal process in place for completing ongoing training. But the pharmacist passed on information to team members when medication was reclassified such as from prescription-only to pharmacy-only or general sale list. Team members said that the pharmacist also passed on information from emails or pharmacy literature. The team discussed informally any advertising campaigns or when seasons changed to discuss what items needed to be stocked. There were no regular times set aside for ongoing training. There were no numerical targets set for the services offered.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy's premises are clean, secure and provide an appropriate environment to deliver its services. People can have a conversation with a team member in a private area.

Inspector's evidence

The pharmacy was clean and bright. People were only using the front three metres of the shop, where a trestle table and plastic screen was positioned. The rest of the store was cordoned off. Two people at a time were served through the plastic screen at separate hatches. People waited outside the shop, on the pavement, for the table to become free. The pharmacy was planning to put a one-way system in place to provide more shelter for the winter months.

The dispensary was small, with limited storage and dispensing space. Stock was organised in a tidy manner on the shelves in the dispensary. The benches were covered with baskets of medicines waiting to be checked by the pharmacist. Multi-compartment compliance packs were dispensed in a room to the rear of the shop.

The consultation room which was easily accessible from the shop floor. The room was clean and allowed private conversations which could not be heard by people in the shop. Hand sanitiser had also been provided for team members. A sink was available for the preparation of medication.The premises were kept secure from unauthorised access. The room temperature and lighting were adequate for the provision of pharmacy services. A fan was available to help regulate the temperature in the dispensary.

Principle 4 - Services ✔ Standards met

Summary findings

Overall, the pharmacy delivers its services in a safe and effective manner. And people with a range of needs can access the pharmacy's services. It gets its medicines from reputable suppliers and manages them appropriately to make sure that they are safe to use. The pharmacy largely dispenses multi-compartment compliance packs in a safe way and supplies the information people need to take their medicines. But it does not always consistently record any details of medicine changes or conversations with people or their carers. The team members said that they will review this.

Inspector's evidence

There was step-free access into the pharmacy and the doors were propped open for better ventilation and to prevent unnecessary contact. Team members would help people if they required assistance. A delivery service was available for patients unable to attend the pharmacy. The number of people using this service had increased greatly during the pandemic. Team members knew what services were available and described signposting people to other providers if a service was not offered at the pharmacy. The pharmacist felt that the delivery service had the most impact as there were a number of housebound and older people. The delivery drivers also kept 'an eye out' on regular people and notified the team if they had any concerns.

The pharmacy had an established workflow in place. Prescriptions were predominantly received electronically. Baskets were used to separate prescriptions and to manage the workflow. There were two people including a pharmacist who were involved as part of the dispensing and checking process. Dispensed and checked-by boxes were available on labels; these were sometimes used by the team.

Team members highlighted when a prescription was received for sodium valproate for someone who fell in the at-risk group. The pharmacist was aware of the change in guidance for dispensing sodium valproate and the associated Pregnancy Prevention Programme. The pharmacy had the relevant warning labels and staff were aware of when these needed to be used. People taking high-risk medicines were monitored appropriately with the pharmacy team members asking people about their recent blood tests and current dose, to ensure that the medicines supplied matched the person's requirements. The need to supply steroid warning cards for long-term users of this medicines was highlighted to the team.

A large number of people were being supplied their medicines in multi-compartment compliance packs. These packs were labelled with the information the person needed to take their medicines in the correct way. The packs also had tablet descriptions to identify the individual medicines. The number of people being supplied with these packs had risen due to other pharmacies in the town stopping providing the service. The pharmacy team had reached its capacity and staff felt that they could no longer add any people to the service in a safe way. The team members were already working outside normal hours to prepare and check the packs. As a result, they had taken the decision to charge people for supplying their medicines in these packs. At the time of the inspection there was no assessment of the individual person's need for packs or other ways of offering support. Following discussion during the inspection the pharmacist undertook to assess people being provided with packs or other support, taking into account the criteria in the Equality Act. There was a list of packs to be dispensed each week, with each person having a summary sheet showing any changes to their medicines and where the medicines were to be placed in the packs. The team members did not always record changes and

conversations with people or their carers, and this was an underlying cause of some issues with packs which had occurred. The team members thought that either a “NOMAD communications book” or putting the information onto each person’s record might solve this issue and were going to discuss which was the best way forward for them.

Some people were supplied with medicines to treat addictions. The pharmacy used an electronic measuring device to measure each dose. Some people using this service had their daily doses supervised to ensure that they were taken. The pharmacy team members were assessing the best way for these people to access the pharmacy if a one-way system was put in place. Currently they had the choice of using the consultation room, or a quiet area of the shop.

The pharmacy provided a delivery service and during the pandemic had increased the number of delivery rounds to three per day. The number of people who the pharmacy delivered medicines to had increased. Signatures were no longer obtained when medicines were delivered, and this was to help infection control. Drivers also stepped back after ringing the doorbell. In the event that someone was not available medicines were returned to the pharmacy. The pharmacy had used volunteer services to help during the peak of the pandemic.

Medicines were obtained from licensed wholesalers. Fridge temperatures were monitored daily and recorded; these were observed to be within the required range for the storage of medicines. CDs were held securely.

Expiry date checks were generally carried out on a rotating basis. There was one date-expired medicine found on the shelves checked. Team members checked expiry dates as part of the dispensing process and dates were also checked by the RP as part of the final check. Out-of-date and other waste medicines were kept separate from stock and then collected by licensed waste collectors.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy generally has the right equipment for its services. It makes sure its equipment is safe to use.

Inspector's evidence

The pharmacy had calibrated glass measures, and tablet counting equipment. Equipment was clean and ready for use. A separate tablet counting triangle was used for cytotoxic medicines to avoid contamination. Two medical fridges of adequate size were also available. The electronic measuring machine was regularly cleaned and calibrated. Up-to-date reference sources were available including access to the internet. The computer in the dispensary was password protected and out of view of people using the pharmacy.

The pharmacy team members had been provided with masks, visors, gloves and hand gel for use as PPE during the pandemic. They regularly wore masks when serving customers, but did not always do so when in the dispensary and other areas of the shop. But social distancing was possible and usually maintained.

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.