General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Farley Hill Chemist, 3 Market Square, Farley Estate, Whipperley Ring, LUTON, Bedfordshire, LU1 5RD

Pharmacy reference: 1028876

Type of pharmacy: Community

Date of inspection: 16/01/2023

Pharmacy context

The pharmacy is in a shopping precinct in a residential area of Luton. It dispenses NHS and private prescriptions, sells over-the-counter medicines and provides health advice. The pharmacy dispenses medicines in multi-compartment compliance aids for people who have difficulty managing their medicines. Services include prescription delivery, supervised consumption, community pharmacist consultation service (CPCS), new medicines service (NMS) and seasonal flu vaccinations.

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

Overall, the pharmacy's working practices are safe and effective. It has adequate standard operating procedures in place to manage risks and make sure its team members work safely. But these are due for review and may not reflect current best practice. The pharmacy team members satisfactorily record their mistakes while dispensing medicines to learn from them and help stop the same mistake happening again. They maintain a dispensing audit trail so they can easily show who completed each step of the process if there is a query. The pharmacy generally keeps the records it needs to by law. Members of the pharmacy team protect people's private information, and they are appropriately trained so they know how to safeguard the welfare of vulnerable people.

Inspector's evidence

The pharmacy had systems to review dispensing errors and near misses. Members of the pharmacy team discussed the mistakes they made to learn from them and reduce the chances of them happening again. They recorded them so they could learn from them and spot patterns or trends with the mistakes they made. The RP explained that medicines involved in incidents, or were similar in some way, such as propranolol and prednisolone or came in different strengths for instance atenolol, were generally separated from each other in the dispensary. The pharmacy team members were alerted to medicines which looked alike or sounded alike (LASA) by warning stickers on the shelf edges where they were stored in the dispensary. The team members recorded incidents and complaints on an incident reporting system on the pharmacy computer. And they reported them to NHS 'learning from patient safety events' (LFPSE) service.

Members of the pharmacy team responsible for making up people's prescriptions used baskets to separate each person's medication and to help them prioritise their workload. They referred to prescriptions when labelling and picking products. And assembled prescriptions were not handed out until they were accuracy and clinically checked by the responsible pharmacist (RP). The RP made sure he took a mental break between dispensing and checking prescriptions when he was working alone. The RP liaised with the practice pharmacist in the nearby surgery to find alternatives to some medicines which were hard to obtain. Team members checked interactions between medicines prescribed for the same person with the RP and recorded interventions on the pharmacy computer system. The team highlighted high-risk medicines in assembled prescriptions with stickers to prompt counselling or adding items from the fridge or controlled drug (CD) cabinet. And the pharmacy gave warning or alert cards which contained additional information to people who took certain medicines such as steroids or methotrexate. Team members followed a protocol to make sure they were handing out prescription medicines to the right people. The pharmacy had had a generator at one time to help keep services going during a power cut. In the event of a systems failure, the pharmacy contacted the surgery and signposted people to other local services.

The pharmacy had standard operating procedures (SOPs) for most of the services it provided. And these were due to be reviewed. Members of the pharmacy team were required to read and sign the SOPs relevant to their roles to show they understood them and would follow them. A member of the team

explained the sales protocol for selling medicines over the counter (OTC). Members of the pharmacy team knew what they could and could not do, what they were responsible for and when they might seek help. And their roles and responsibilities were described in the SOPs. A team member explained that they would not hand out prescriptions or sell medicines if a pharmacist was not present. And they would refer repeated requests for the same or similar products, such as medicines liable to abuse, misuse or overuse, to a pharmacist. The pharmacy had a complaints procedure. The pharmacy asked people for their views and suggestions on how it could do things better. And it had received positive feedback from people online, verbally or by phone.

The pharmacy had risk-assessed the impact of COVID-19 upon its services and the people who used it. Members of the pharmacy team had self-tested for COVID-19 twice weekly. To help protect against infection with the virus, screens were fitted along the medicines counter and the floor was marked to show people where to stand at a distance from other people. At the time of the visit, team members wore fluid resistant face masks to help reduce the risks associated with the virus. And they applied hand sanitising gel when they needed to.

The pharmacy team had undertaken audits to monitor services. And these included audits of owing or outstanding prescription medicines, waste medicines and how long the service took for processing an acute prescription. The RP had monitored the impact on the pharmacy systems of repeat prescriptions increasing to 84 days supply. And the results of the audit showed the effects on storage, stock holding and the amount of waste medicines.

The pharmacy had appropriate insurance arrangements in place, including professional indemnity, for the services it provided. The pharmacy displayed a notice that told people who the RP was. And it kept a record to show which pharmacist was the RP and when. The pharmacy had an electronic CD register and the person accessing its CD information had to enter a PIN and sign in. A random check of the actual stock of a CD matched what was recorded in the CD register. Ensuring methadone instalments for supervised consumption were correctly labelled was discussed. The pharmacy kept records for the supplies of the unlicensed medicinal products it made. And these generally were in order. But the name and address of the prescriber were sometimes incorrectly recorded.

The pharmacy was registered with the Information Commissioner's Office. And a notice was being re-printed that told people how their personal information was gathered, used and shared by the pharmacy and its team. The team tried to make sure people's personal information could not be seen by other people and was disposed of securely. A member of the team described how people's private information was protected. The pharmacy team had completed level 1 safeguarding training. And the RP had completed a level 2 safeguarding training course so members of the pharmacy team knew what to do or who they would make aware if they had concerns about the safety of a vulnerable person. The RP was signposted to the NHS safeguarding App.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy's team members work well together delivering services safely and managing their workload. The pharmacy supports them in completing appropriate training and they understand their roles and responsibilities. Members of the team feel able to provide feedback on how the pharmacy could improve its services.

Inspector's evidence

The pharmacy team consisted of the RP, a regular locum pharmacist who covered Fridays, two part-time and one full-time dispensing assistants, a part-time trainee medicines counter assistant and two part-time delivery drivers. The pharmacy relied upon its team to cover absences. And the RP sometimes could call on a family member who was a pharmacist to help with the workload too. The RP was supported at the time of the inspection by three team members.

Members of the pharmacy team had completed or were undertaking accredited training relevant to their roles. They were allocated protected learning time to study. They worked well together, and people were served quickly, and their prescriptions were processed safely. The RP supervised and oversaw the supply of medicines and advice given by the pharmacy team. The pharmacy had an OTC sales and self-care SOP which its team followed and there were printed copies of the protocol for reference if needed. This described the questions the team members needed to ask people when making OTC recommendations. They knew when they should refer requests to a pharmacist. The RP had undertaken the required training to complete the declaration of competence to deliver the flu and COVID-19 vaccination services. Some of the training had been provided by the local surgery.

The pharmacy team members were signposted to the GPhC Knowledge Hub. The RP could communicate individually or via a WhatsApp group with the team. And members of the team could write reminders and messages on a white board in the dispensary. The pharmacy did not set targets or incentives for its team. Members of the pharmacy team could make decisions to help keep people safe. They were comfortable about providing feedback on how to improve the pharmacy and its services. For example, team members discussed how they would cover the hours when other members of the team were on annual leave and they suggested retail items the pharmacy should stock. They knew how to raise a concern if they had one.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean, bright, secure and suitable for the provision of healthcare services. The pharmacy prevents people accessing its premises when it is closed so its medicines stock is safe, and people's private information is protected.

Inspector's evidence

The registered pharmacy premises were bright, clean and secure. And the pharmacy was well ventilated, so it did not get too warm. The pharmacy had a large retail area, a wide medicines counter and seating for people who were waiting for prescriptions. The spacious dispensary was raised giving a good view of the medicines counter and retail area. The dispensary benches were tidy and there was a separate area where multi-compartment compliance aids were prepared. The pharmacy had a consultation room where people could have a private conversation with a team member. It was tidy and clean. There was also a private area with a hatch connecting it to the dispensary where people could access the supervised consumption service. There was extensive storage and staff facilities at the back of the pharmacy.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's working practices are generally safe and effective. The pharmacy team members make sure people with different needs can easily access the available services. The pharmacy obtains its medicines from reputable suppliers and stores them securely at the right temperature, so they are safe to use. The pharmacy team members identify people using high-risk medicines and make sure they have the information they need to use their medicines safely. Team members know what to do in response to alerts and product recalls and return any medicines or devices to the suppliers.

Inspector's evidence

The pharmacy had a single door wide enough for wheelchair access. And its entrance was level with the outside pavement. This made it easier for people to enter the building. The pharmacy team tried to make sure people could use the pharmacy services. The pharmacy had a notice that told people when it was open. And other notices in its window told people about some of the other services the pharmacy offered. The pharmacy had seating for people to use if they wanted to wait. Members of the pharmacy team were helpful and spoke or understood Bengali, Hindi, Punjabi, Urdu, Italian, Portuguese and Bulgarian which helped people whose first language was not English. And they signposted people to other providers such as NHS 111, the local doctor's surgery or optician if a service was not available at the pharmacy.

The pharmacy provided a delivery service to people who could not attend its premises in person. And it kept an audit trail for the deliveries it made to show that the right medicine was delivered to the right person. There was a QR code displayed by one wholesaler in the dispensary with the pharmacy's details. And the delivery person for that company had to scan the QR code before leaving the delivery of medicines to show it had been left at the right pharmacy. The pharmacy sold COVID-19 rapid lateral flow tests that people could use at home.

The pharmacy provided the flu and COVID-19 vaccination service via the national protocols to people over 18 years of age and mostly on a walk-in basis. The RP described the SOP for administering a flu vaccination starting with arrival of the person, the clinical assessment, vaccination, advice and record keeping. People were directed to the seating area where a team member got their details. Records including consent and vaccine details were maintained on PharmOutcomes which also generated an email to inform the person's surgery about the vaccination. At the time of the visit, the COVID-19 vaccination service had paused. But the RP explained that the vaccine was administered via the national protocol and mostly on a walk-in basis. The RP had completed appropriate training, some of which was at the local surgery, in tasks such as preparation of the Pfizer vaccine. At the onset of the COVID-19 programme and lock-down, the pharmacy had separate teams to help deal with the additional workload while still providing the pharmacy's usual services. The pharmacy had informed its insurers about all the pharmacy's activities to make sure appropriate insurance cover was in place.

The pharmacy used disposable packs for people who received their medicines in compliance aids. People mostly re-ordered their own prescriptions. And following a hospital stay, the pharmacy received information via the discharge medicines service. The pharmacy team checked whether a medicine was suitable to be re-packaged. Labelling included a brief description so people could identify each medicine contained within the compliance aids. But it did not always provide patient information leaflets. So, people did not always have the information they needed to make sure they took their medicines safely. The RP gave an assurance that PILs would be supplied with each set of compliance aids. The pharmacy also provided the new medicines service (NMS) to help people get the most from their new medicines by resolving issues such as side effects. The service was monitored and people were followed up by phone after the initial consultation.

Members of the pharmacy team could identify which of them prepared a prescription and they marked some prescriptions to highlight when a pharmacist needed to speak to the person about the medication they were collecting or if other items needed to be added. The RP was aware of the valproate pregnancy prevention programme and that girls or women in the at-risk group who were prescribed a valproate needed to be counselled on its contraindications. The RP explained that the dispensing label should not cover the educational information on the dispensing carton, that these people should be given a patient card and be reviewed annually by a specialist. The pharmacy received referrals for emergency supplies or treating minor ailments for the community pharmacist consultation service (CPCS) via PharmOutcomes.

The pharmacy used recognised wholesalers to obtain its pharmaceutical stock. It kept its medicines and medical devices in their original manufacturer's packaging. The pharmacy team regularly checked the expiry dates of medicines. And it recorded when it had done a date-check. No expired medicines were found on the shelves amongst stock. The pharmacy stored its stock, which needed to be refrigerated, between two and eight degrees Celsius. And it stored its CDs, in line with safe custody requirements, securely. The pharmacy had procedures for handling the unwanted medicines people returned to it. And these medicines were kept separate from stock in pharmaceutical waste bins. The pharmacy had a procedure for dealing with alerts and recalls about medicines and medical devices. And the RP described the actions they took when the pharmacy received a concern about a product from the MHRA. How these actions were recorded was under review.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs for the services it offers. The pharmacy uses its equipment appropriately and keeps people's private information safe.

Inspector's evidence

The pharmacy had a plastic screen on its counter. And hand sanitisers for people to use. Team members chose to wear fluid resistant face masks. The pharmacy had glass and plastic measures for use with liquids, and some were used only with certain liquids. The pharmacy team had access to up-to-date reference sources. The pharmacy had two refrigerators to store pharmaceutical stock requiring refrigeration. And its team regularly checked the maximum and minimum temperatures of both refrigerators. The pharmacy had had a generator to provide power in an emergency. There were two CD cabinets to store CD stock and CD prescriptions awaiting collection. The pharmacy had adrenaline ampoules with syringes for dealing with anaphylaxis following a vaccination.

The pharmacy collected confidential wastepaper for shredding. It restricted access to its computers and patient medication record system. And only authorised team members could use them when they put in their password. The pharmacy positioned its computer screens so they could only be seen by a member of the pharmacy team. Some of the NHS cards belonging to the team required updating and the RP was in the process of arranging the update.

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.