General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Walton Chemist, 178A Mountsteven Avenue, Walton, PETERBOROUGH, Cambridgeshire, PE4 6HN

Pharmacy reference: 1029330

Type of pharmacy: Community

Date of inspection: 01/08/2022

Pharmacy context

This community pharmacy is in a residential area on the outskirts of Peterborough, Cambridgeshire. Its main services include dispensing NHS prescriptions, selling over-the-counter medicines and providing health advice to people. The pharmacy supplies some medicines in multi-compartment compliance packs, designed to help people remember to take their medicines. And it offers a medicine delivery service to people's homes. The pharmacy changed ownership in July 2021 from a large multiple to an independent owner.

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 acts appropriately to identify and manage risks associated with providing its services. It advertises how people can provide feedback about its services. The pharmacy generally keeps the records it needs to by law. And it protects people's confidential information appropriately. Pharmacy team members act openly and honestly by discussing their mistakes and they act to reduce risk following these discussions. They understand how to safeguard potentially vulnerable people.

Inspector's evidence

The pharmacy had standard operating procedures (SOPs) to support its safe running. These covered responsible pharmacist (RP) requirements, controlled drug (CD) management, dispensary processes and services. And they had been implemented within the last year. The majority of team members had signed SOPs to confirm their understanding of them. But several team members that had commenced roles in the pharmacy within the last few months had yet to sign SOPs. The superintendent pharmacist (SI) discussed learning completed by these team members to date as they worked through their induction. Pharmacy team members discussed their roles and responsibilities with confidence. And they understood what tasks could not take place if the RP took absence from the premises.

The pharmacy was in the process of implementing an electronic record management system. This would see changes to some patient safety process, and the SOPs transferred to electronic access with training records provided through the system. This meant details within some SOPs required updating to reflect new processes. Team members had begun to use patient safety features of the system recently by recording their near misses electronically. And the new electronic reporting tool did support a structured review process by providing trend analysis information. Prior to this very recent change team members recorded near misses on a paper record. Members of the pharmacy team explained that they engaged in conversations about near misses and acted to reduce risk following mistakes made during the dispensing process. For example, separating 'look-alike and sound-alike' medicines on the dispensary shelves. But the team had not recorded the outcome of these conversations to date. This meant it was more difficult for it to identify trends in near misses. And to show how it applied continual learning to reduce risk during the dispensing process. The pharmacy currently used the patient medication record (PMR) system to record dispensing incidents. The SI stated that there had been no incidents reported to him since the change of ownership.

The pharmacy advertised its feedback procedures clearly. And team members were observed being attentive to people's needs. Feedback left on the pharmacy's profile on the NHS.UK website was positive and reflected good levels of customer service. The pharmacy advertised how it used and stored people's confidential information within a helpful leaflet. It held personal identifiable information within staff only areas of the premises. And it displayed its registration status with the Information Commissioner's office. Team members followed secure processes for disposing of confidential waste. The pharmacy had procedures relating to safeguarding vulnerable adults and children. Pharmacy team members had completed some safeguarding learning. And they had clear guidance relating to reporting safeguarding concerns and signposting information available to refer to when needed. A team member provided an example of how they had recently signposted a person to seek support for their mental health.

The pharmacy had up-to-date indemnity insurance arrangements in place. The RP notice displayed the correct details of the RP on duty. The pharmacy maintained running balances in its electronic CD register. Physical balance checks of stock against the register took place monthly. A random physical balance check conducted during the inspection complied with the running balance in the register. The pharmacy had a patient returned CD destruction register, but team members did not always record returns in the register on the date of receipt. The RP record contained sign-in times and details of the RP but it did not include sign-out times of the RP. This meant it could be difficult for the pharmacy to accurately address any queries that arose relating to RP presence. Team members generally completed records relating to the dispensing of private prescriptions accurately within an electronic register. But there was a need to ensure full details of prescribers were included within these entries. Records associated with the supply of unlicensed medicines included full audit trails of the supply made.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough, suitably skilled team members to manage its workload effectively. Pharmacy team members work well together and take regular opportunities to engage in learning relating to their roles. They understand how to provide feedback about the pharmacy and can raise a professional concern if needed.

Inspector's evidence

The SI worked full-time at the pharmacy alongside three qualified dispensers, a trainee dispenser and a delivery driver. The pharmacy had employed the trainee dispenser and delivery driver recently. The SI was aware of the requirement to enrol team members on a GPhC accredited training course to support them in their role within three months of them commencing work at the pharmacy. The pharmacy had a business continuity plan and this was accessible to its team members along with contact information for locum pharmacists if required. The pharmacy had seen an increase of over 100% in the number of items it dispensed within the last year. Staffing levels had been adjusted in response to this. The pharmacy did not have specific targets associated with it services. Team members were encouraged to focus on providing a positive experience to people using the pharmacy.

Pharmacy team members engaged in regular learning relating to their roles. This had recently included a team member completing some learning ahead of the pharmacy providing a smoking cessation service. And some recent e-learning relating to safeguarding vulnerable people. One team member had recently explored learning relating to the management of medicines subject to abuse and misuse. Team members received regular opportunities to engage in both team discussions and one-to-one conversations with the SI. And reported feeling confident in providing feedback to the SI. A team member understood how they could escalate a concern at work including referring a concern to the GPhC or other relevant organisation should they need to.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are clean and secure. Members of the pharmacy team work well in the limited space provided. And they promote access to the pharmacy's private consultation facilities.

Inspector's evidence

The pharmacy was small, but it was clean and secure against unauthorised access. The premises consisted of a small public area with a private consultation room to the side of this area. Team members used a separate entrance to the room from the back of the medicine counter, this allowed them to control access appropriately as the public-facing door remained locked between use. The use of this private consultation space was seen to be offered to people. The dispensary was small for the volume of work taking place. But team members worked well to manage the available space. For example, the team had protected space available to complete tasks associated with the assembly of multi-compartment compliance packs.

The SI had recognised that space for storing items such as medicine waste and dispensary sundries was becoming an issue. And had acted to review the situation and apply for a first-floor extension of the premises which was awaiting planning permission. Lighting was bright throughout the pharmacy and air conditioning ensured the pharmacy stored medicines under 25 degrees Celsius.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy makes its service accessible to people. And it provides its services in an organised and safe manner. It obtains its medicines from reputable sources. And it generally stores these medicines safely and securely. Pharmacy team members provide appropriate information when supplying medicines to help people use them correctly.

Inspector's evidence

People accessed the pharmacy through a simple door from street level. The pharmacy had a wide-ranging display of health information available for people to read in the public area of the pharmacy. Further information in the consultation room provided pictorial guides associated with hypertension management and the treatment of anaphylaxis reactions. The pharmacy was actively working to increase the number of services it provided. This included being involved in the East of England Community Pharmacy IT Pilot programme which involved pharmacist read and write access to people's GP records.

Pharmacy team members used NHS secure email to communicate directly with GP surgeries. This provided an audit trail of information relating to prescription queries. And the team asked for consent to notify people's own GPs of the outcome of services, such as the NHS hypertension case-finding service. The team had also set up a record on the PMR system which captured correspondence between the pharmacy and the local substance misuse team. This allowed team members to view the PMR efficiently and it provided a robust audit trail of information between the two services. The SI also demonstrated how a documents section on individual PMRs was used to save scanned documents relating to people's ongoing care needs. Pharmacy team members identified higher-risk medicines during the dispensing process. And the pharmacy had a range of information and tools to prompt further conversations with people taking these medicines. But team members did not generally record the outcome of these monitoring conversations on people's PMR. Pharmacy team members demonstrated a good awareness of the requirements related to the valproate pregnancy prevention programme. And the pharmacy had resources associated with the valproate pregnancy prevention programme (PPP) to hand.

The pharmacy protected Pharmacy (P) medicines from self-selection as it displayed them behind the medicine counter. Pharmacy team members discussed how repeat requests for higher risk over-the-counter medicines would be referred to the RP. Pharmacy team members signed the 'dispensed by' and 'checked by' boxes on medicine labels when dispensing medicines. And they used baskets to help manage individual prescriptions safely. The pharmacy used a module on the PMR system to manage the supply of medicines in multi-compartment compliance packs. A progress sheet helped the team monitor the receipt of prescriptions and the completion of weekly workload associated with this service. Assembled compliance packs generally included full dispensing audit trails of those involved in the dispensing process. And the pharmacy team regularly supplied patient information leaflets to people receiving their medicines in this way. The current delivery service did not include a robust audit trail of the medicines the pharmacy delivered. This meant it may be difficult for team members to answer queries relating to a delivery when they arose. The SI discussed how the new record management system being implemented included an electronic tracking system for all deliveries.

The pharmacy sourced medicines from licensed wholesalers. It kept a robust audit trail of the orders it sent to licensed specials manufacturers to help manage any queries. It stored medicines in an orderly manner, and generally within their original packaging, on shelves throughout the dispensary. An unlabelled amber bottle containing some capsules was found to be stored in front of boxes of Madopar capsules. The SI acknowledged this was not an acceptable way to store medicines and acted immediately to dispose of the medicine safely. The pharmacy stored stock and assembled CDs appropriately within a secure cabinet. But it held patient-returned CDs and out-of-date stock CDs in a secure cabinet alongside other items. The SI acknowledged the requirement to arrange for an authorised witness to visit to witness the destruction of out-of-date CD stock. The pharmacy stored medicines subject to cold chain requirements safely in a pharmaceutical refrigerator. It kept a fridge temperature record but there were minor gaps in recording noted. The fridge was recorded to be operating between two and eight degrees Celsius as required between these gaps. The pharmacy did not supply a separate fridge for its team members. This meant they stored milk within the medicine fridge. This was not ideal but care was taken to ensure the milk was stored upright to prevent it from contaminating medicines inside the fridge

Pharmacy team members reported completing regular date checks across all stock. And a record of recent date checking tasks had been completed. A random check of dispensary stock found no out-of-date medicines. But the team did not always annotate bottles of liquid medicines with details of their opening dates. This meant it could be more difficult for team members to assure themselves that these medicines remained safe and fit to supply. The pharmacy had appropriate medicinal waste bins available. The team received medicine alerts by email, and it kept audit trails of the alerts it actioned.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs for providing its services. And pharmacy team members act with care by using the equipment in a way which protects people's confidentiality.

Inspector's evidence

The pharmacy had up-to-date written reference resources available including the British National Formulary (BNF). Pharmacy team members accessed password-protected computers and used NHS smartcards when accessing people's medication records. The pharmacy suitably protected information on computer monitors from unauthorised view. It stored bags of assembled medicines on designated shelving to the side of the medicine counter out of direct view of the public area.

Pharmacy team members used appropriate counting and measuring equipment when dispensing medicines. The pharmacy had separate equipment available for counting and measuring higher risk medicines. This mitigated any risk of cross contamination when dispensing these medicines. Equipment used to support the delivery of pharmacy services was from reputable manufacturers. For example, the pharmacy's blood pressure monitor was on the list of monitors validated for use by the British and Irish Hypertension Society. And a carbon monoxide machine had been sourced through the local authority's smoking cessation lead. Electrical equipment was in working order and cables and plugs were visibly free from wear and tear. Portable appliance testing of this equipment had taken place within the last two years.

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.