General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Odedra Chemist, Rectory Gardens, Old Fletton, PETERBOROUGH, Cambridgeshire, PE2 8HN

Pharmacy reference: 1029341

Type of pharmacy: Community

Date of inspection: 15/10/2019

Pharmacy context

This pharmacy is situated in a largely residential area, next to a busy GP surgery. It offers all the essential pharmacy services including dispensing NHS prescriptions and receiving waste medicines for safe disposal. It offers a prescription delivery service. And it supplies medicines in multi-compartment compliance packs to a large number of people. Medicines Use Reviews (MURs) and New Medicine Service (NMS) checks are undertaken by the pharmacist. Some people receive instalment supplies for substance misuse treatment. And the pharmacy provides flu vaccinations seasonally.

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's team members generally follow safe practices. They understand what they can and cannot do when there is no pharmacist present. They know how to keep people's private information safe. And they make improvements to the way they work, so they can reduce risks and manage their workload better. But they don't always record the reasons why mistakes have happened. So, they may be missing opportunities to learn from these events and identify ways to make their services better.

Inspector's evidence

The pharmacy had written standard operating procedures (SOPs). The new superintendent had replaced the previous SOPs in May 2019 with templates produced by the pharmacy's insurers. The pharmacy manager was reviewing and making local amendments to these to make sure they reflected this pharmacy's activities before issuing to the staff. The procedures covered dispensing activities, management of controlled drugs (CDs), over-the-counter medicines sales, safeguarding vulnerable people, the pharmacy delivery service, and supplying medicines in multi-compartment compliance packs. There were also written procedures about protecting people's information and dealing with dispensing errors or other adverse incidents.

To reduce the risks posed by distraction, compliance packs were dispensed in a separate dispensary upstairs. The team members involved in this activity were not sure if any near misses encountered with these packs were recorded but they were told about their mistakes. The team members in the main dispensary said that the pharmacist usually pointed out any dispensing mistakes and staff were asked, where possible, to correct their own mistakes. These incidents were sometimes recorded but the details written down had very little information about exactly what had gone wrong and what may have caused the mistake. The records seen were made by the pharmacist rather than the person who made the mistake. And the next steps were generally 'double check'. The pharmacist said he would review how these events were captured so they could make the most of the opportunity to learn and improve.

There was a process to record and report any errors which reached patients. There was some evidence that learning points from near misses and errors were shared with the team. Some medicines with similar sounding names, similar packs, or with multiple strengths had been more clearly separated on shelves to prevent selection errors. For example, pantoprazole and propranolol had been moved to two separate areas. The pharmacy had also brought in an external consultant to review processes and suggest improvements; this had been welcomed by the team. A new form had been introduced to help advise people about owed prescription items and this was said by staff to have reduced their workload and made the process clearer for patients. The consultant had also introduced changes to how compliance packs were labelled so there was less handwriting by staff required. This had also been felt to reduce workload for the team.

When asked, the team members could confidently explain what they could and couldn't do in the absence of a responsible pharmacist (RP). Prescription labels, including those on compliance packs, were initialled at the dispensing and checking stages. This meant the pharmacy could be sure who had completed each of these tasks. Team members were observed asking people questions before selling medicines to establish if it was safe to proceed with a sale. They could explain which medicines were

more closely controlled to minimise the risk of misuse, for example, pseudoephedrine-containing medicines and codeine-containing painkillers. And the staff referred queries to the pharmacist throughout the visit.

The pharmacy sought feedback from people about its services using an annual survey. Results from the most recent survey were very positive. There was a complaints procedure which enabled people to raise concerns about the pharmacy and staff would refer people to the pharmacist if needed. There was some information in the pharmacy leaflet about how to make comments or complaints.

The pharmacy's services were appropriately insured. The RP notice showed who the pharmacist in charge was and it was displayed where the public could see it. The RP record was complete and provided information about who had been the pharmacist in charge of the pharmacy. Records about Schedule 2 CDs were largely complete and running balances were kept and checked regularly. A small number of headers had not been filled in which could increase the chance of entries being made in the wrong register. Patient-returned CDs were recorded when received. Private prescriptions and emergency supplies were recorded in a book. Private prescriptions were not always recorded within the required timeframe. The pharmacist agreed to make sure these were entered promptly in future.

The pharmacy protected sensitive information in several ways. Confidential waste was segregated and disposed of securely. Staff had read and signed the written procedures about information governance. A privacy notice was displayed, telling people how their information was used. Patient medication records were password protected and could not be viewed from the shop floor. And staff used their own NHS smartcards to access electronic prescriptions and kept their passwords private. The pharmacy manager had some awareness of the General Data Protection Regulation, but staff had not had any specific training on it.

There were procedures to help make sure the pharmacy took appropriate action to protect vulnerable people. Apart from the pharmacist who had completed updated level 2 safeguarding training, staff had not had any recent training on the topic. However, they had completed Dementia Friends training and knew where to find contact information for local safeguarding agencies if there were concerns to report. The team members were able to give examples of reacting appropriately to concerns about vulnerable people and providing additional support to help some people with compliance difficulties take their medicines safely.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy's team members are suitably trained or are doing the right training for the roles they undertake. They can share ideas to improve how the pharmacy operates. And they can raise concerns if needed. They receive some support in keeping their skills and knowledge up to date. There are opportunities for the team to be more involved in learning from events such as near misses.

Inspector's evidence

At the time of the inspection there was the pharmacist (the pharmacy manager), one trainee dispenser working in the upstairs dispensary, three trained and one trainee dispenser in the main dispensary. The team was busy throughout but appeared to be coping with their workload. There were some staff members on leave. Members of staff worked closely together and communicated well with each other and with their customers.

All team members had completed or were completing the required accredited training for their roles. They received help with their training from each other and the pharmacy manager. Aside from accredited training, staff also used promotional materials and trade publications to update their knowledge on new medicines. Information was passed across the team via an electronic messaging group.

The staff had limited opportunities to do training when at work but tried to fit it in when it was quiet. Team members said they would feel comfortable raising any concerns or making suggestions to improve how the pharmacy operated with the pharmacy manager or with another member of the management team who visited the pharmacy regularly. This person also held regular one-to-ones with the staff and had conducted appraisals with the team; these were last done in 2018.

The pharmacist explained that he felt able to exercise his professional judgement when delivering services, considering the needs of his patients and his capacity to provide additional services safely. This was not affected by targets.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy's premises are safe, secure, and suitable for the services it provides. The pharmacy generally presents a professional image to people who use its services.

Inspector's evidence

The pharmacy was generally well-presented and well-maintained. Aisles in the shop area were kept free of clutter and the premises were reasonably clean throughout. A cleaner attended once a week. Quieter parts of the premises were used for specific tasks such as preparing multi-compartment compliance packs, so distractions were fewer. And the pharmacist reserved a section of the dispensing bench to use for accuracy checking prescriptions.

The pharmacy was at street level so was accessible to people with wheelchairs or prams. There was seating available for people waiting for services. A well-screened consultation room was also available and signposted. It was used for Medicines Use Reviews, flu vaccinations, and private conversations with people. The room was large enough to enable access by wheelchair users and there was seating available. However, various pieces of equipment and paperwork were left on display and made the room look cluttered. There was a hatch at one end of the dispensary, away from the main counter, which afforded additional privacy for people receiving some services.

There was a sink in the dispensary equipped with hot and cold running water and separate handwashing facilities for staff. These were both reasonably clean.

The pharmacy could be secured against unauthorised access. The dispensary was separated from the rest of the shop and was not easily accessible by members of the public. Prepared medicines were held out of reach and sight of the public. Room temperatures were controllable, and levels of ventilation and lighting were appropriate during the visit.

Principle 4 - Services ✔ Standards met

Summary findings

Overall, the pharmacy's services are undertaken safely and effectively. It gets consent from people for the services it provides to them. It takes the right action in response to medicine recalls and safety alerts to protect people's health and well-being. And it gets its medicines from reputable sources and generally stores them and other stock safely. It could do more to make sure that people who receive some higher-risk medicines get all the advice they need.

Inspector's evidence

The pharmacy staff clearly knew their regular customers and had a good rapport with them. There was some information displayed in the pharmacy about the services it provided and its opening hours. There was also information available about other healthcare matters and services provided by other agencies. The pharmacy displayed its practice leaflet where people could pick it up and this held information about its services. As part of a commissioned service, the pharmacy provided health checks such as blood pressure and blood glucose testing. People were provided with advice and referred to their GP if needed.

Dispensing was undertaken in an organised manner. Baskets of different colours were used to separate prescriptions and prioritise the workload. There was an audit trail on all dispensed items showing who had dispensed and checked the medicines.

The pharmacist was aware of the need to provide information about pregnancy prevention to patients who may become pregnant who were supplied valproate-containing medicines. However, the pharmacy had no warning stickers to apply to dispensed medicines and no patient safety literature to hand out to people. The pharmacist said he would order new supplies of these. To help manage the risks associated with some other higher-risk medicines, there were alert stickers for controlled drugs (CD) to highlight when additional care was needed when prescriptions for these items were handed out. However methotrexate and warfarin were not similarly highlighted. This could make it harder for the pharmacy to be sure that people always receive the advice they need to take their medicines safely.

Medicines were supplied in multi-compartment compliance packs for some people who needed this level of support. These were prepared in accordance with a four-week rota and in a separate upstairs dispensary to reduce distractions. Prescriptions were ordered on behalf of some people and missing items or unexpected changes were queried with the person or their GP. Records of any interventions or changes were made on people's records. Patient information leaflets (PILs) were provided regularly, and the compliance packs were fully labelled and included tablet descriptions. Staff could explain the types of medicines they generally wouldn't put in the compliance packs, for example, medicines with varying doses or medicines which were hygroscopic. Where people had reducing doses over a period of months, the pharmacy checked the correct dose with the person's GP on each supply. There was a process to retrieve and reissue new packs if changes were made to people's medication mid-cycle.

The pharmacist had completed the necessary refresher training to safely provide the seasonal flu vaccination service under a patient group direction. The consultation room was suitable for this service

and the pharmacy had the right equipment available. He was observed obtaining consent and confirming that exclusion criteria did not apply to people attending for this service before administering vaccinations.

The drivers sometimes got signatures from the people to whom they delivered medicines. This could make it harder to show that medicines have reached their intended recipients if there was a future query. Th drivers would only post medicines through letterboxes or leave with neighbours where this had been risk assessed and agreed with patients or carers.

The pharmacy got its medicines from licensed wholesalers and specials were obtained from specials manufacturers. No extemporaneous dispensing was carried out. Medicine stock for dispensing was stored in an orderly fashion, out of reach of the public. CDs were stored securely. There was a process to date-check stock regularly and this activity was recorded. Short-dated stocks were highlighted to reduce the risk of supply beyond the expiry date. Dates of opening were applied to most liquids which had reduced shelf-lives once opened. No out-of-date medicines were found when stock was spot-checked. One pack contained two different brands of medicine. The pharmacy manager was advised this could make date-checking less effective and to keep all medicines in appropriately labelled containers. Out-of-date medicines and patient-returned medicines were transferred to designated bins and these were stored away from dispensing stock.

The staff had not yet completed any training about the Falsified Medicines Directive (FMD). The company was currently deciding on which equipment supplier to use and would ensure that staff received the relevant training to support its introduction. Appropriate arrangements were in place for storing CDs. There was enough storage capacity for medicines requiring refrigeration. The medicines fridges were equipped with a maximum and minimum thermometer and temperatures were checked daily and recorded. The records seen were within the appropriate range. The pharmacy had a process to receive drug recalls and safety alerts direct from the MHRA and other sources. The pharmacy provided evidence of how it had received and acted on recent alerts.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs to provide its services safely. It generally maintains its equipment appropriately, so it is safe to use.

Inspector's evidence

The pharmacy had a range of up-to-date reference sources available to support its services. Patient records were stored electronically and there were enough terminals for the workload undertaken. Access to these was password protected. Computer screens were not visible to the public. The staff had access to cordless phones and could move to quiet areas of the dispensary to make phone calls out of earshot of waiting customers.

There were suitable, clean measures available to measure liquids accurately. Other counting equipment, which included tablet triangles, was clean. The pharmacy had a blood pressure meter and a blood glucose meter which both looked to be in good condition but there was no formal process to replace them or check they were working properly. This could make it harder for the pharmacy to be sure that the corresponding results provided are always accurate. The pharmacist said he would establish a replacement cycle and use control solution checks in future. Other electrical equipment appeared to be in good working order and was safety checked. Fire safety equipment and alarms were checked and serviced regularly. The fridge temperatures were checked daily and recorded. The records viewed showed that temperatures had remained within the appropriate range for storing medicines safely.

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.