General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Shrives Chemist, 14 Westgate, PETERBOROUGH, Cambridgeshire, PE1 1RA

Pharmacy reference: 1029349

Type of pharmacy: Community

Date of inspection: 24/02/2020

Pharmacy context

This community pharmacy is located on a high street in the city centre. Its main activity is dispensing NHS prescriptions. It delivers some medicines to people's homes. And it supplies medicines in multi-compartment compliance packs to some people who need help remembering to take their medicines at the right times. The pharmacy also offers seasonal flu vaccinations. The pharmacy's owner provides most of the pharmacist cover at the pharmacy.

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 manages risks in an adequate manner. It has written instructions to tell staff how to work safely. The pharmacy's team members learn from their mistakes and they make changes to reduce the chances of similar mistakes being made in the future. They know how to keep people's private information safe. And the pharmacy has processes in place to protect vulnerable people. Most of the pharmacy's records are complete and it keeps them up to date. But some of its records are very difficult to read. This could make it harder to refer to these in future.

Inspector's evidence

The pharmacy had written standard operating procedures (SOPs). The owner reviewed the SOPs periodically to make sure they reflected the pharmacy's activities. The procedures included dispensing activities, management of controlled drugs (CDs), over-the-counter medicines sales, safeguarding vulnerable people, the pharmacy delivery service, and dealing with dispensing incidents or complaints about the pharmacy's services. There was some indication of roles and responsibilities in the SOPs and most of the staff had read SOPs relevant to their roles. The owner had identified which SOPs still needed to be read by the locum pharmacist was setting aside time for her to be able to do this.

There was a process to record, report and review any dispensing errors which had reached patients. Following a recent incident where the wrong medicine had been dispensed, the incident had been reviewed to understand how it had happened and the items involved moved further apart to prevent future selection errors. The matter had also been reported to the National Reporting and Learning System and it had been discussed within the team to raise awareness. Both pharmacists were aware of the potential risks of self-checking prescriptions. Wherever possible, there was a second independent check of dispensed items. The pharmacy technician was working some additional hours to reduce the need for pharmacists to self-check prescriptions whilst the pharmacy tried to recruit an additional dispenser. When it wasn't possible to avoid self-checking, the pharmacists described how they separated dispensing and checking activities, moving dispensed medicines to a different workbench before doing a final accuracy check and taking a mental break between the two stages to reduce risks.

There was also a process to record those mistakes, referred to as near misses, which were spotted and corrected during the dispensing process. The log showed that near misses were recorded routinely, and the records had some information about the possible reasons why the mistakes had been made and how to prevent them happening again. The owner said he discussed near misses with the team but didn't review them to spot any patterns or trends. Some medicines with similar sounding names, similar packs, or with multiple strengths had been more clearly separated on shelves to prevent selection errors. The owner had also taken a photograph of several products with identical packaging and had shared this with his staff, so they were aware of the risks when putting away or when selecting medicines for dispensing.

When asked, the team members could confidently explain what they could and couldn't do in the absence of a responsible pharmacist (RP). The trainee assistant who worked in the photographic section knew that she could not give any advice about medicines or health-related matters and referred any queries to the pharmacists. 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. And the staff referred queries to the pharmacists throughout the visit.

The pharmacy sought feedback from people about its services using an annual survey. It was still to complete the 2019 to 2020 survey. Results from the 2017 to 2018 survey were displayed on the NHS website. There was a complaints procedure which enabled people to raise concerns about the pharmacy and staff would refer people to the pharmacist if needed. Some details about this were included in the pharmacy's practice leaflet on display.

The pharmacy had current professional indemnity and public liability insurance. The RP notice showed who the pharmacist in charge was and it was displayed where the public could see it. The RP record was largely complete and provided information about who had been the pharmacist in charge of the pharmacy. A few entries did not include the time at which the RP finished their shift, but it was invariably the pharmacy owner and he was also on duty the following day. Records about Schedule 2 CDs were largely complete and running balances were kept and checked regularly. Some of the writing in the register was difficult to read. Patient-returned CDs were recorded when received; all previous returned CDs had been destroyed and there were denaturing kits available. Private prescriptions and emergency supplies were recorded in a book. Private prescription records were largely complete though, again, the details were very difficult to read in places. Emergency supply records had a good level of information about the reason for the supply but did not always include the date of the supply. The owner agreed to make sure these were recorded fully in future and to make the records more legible.

To protect people's confidentiality, waste containing sensitive information was disposed of by shredding. Information governance arrangements were reviewed periodically. The owner said he had written procedures about information governance but had taken these home to review them. There was a leaflet for people about how their information was safeguarded. Patient medication records were password protected and could not be viewed from the shop floor. The pharmacist was using her own NHS smartcard to access electronic prescriptions; she said that she did not disclose her password to anyone else.

There were procedures to help make sure the pharmacy took appropriate action to protect vulnerable people. There was a chaperone policy for use of the consultation room. The pharmacists had completed level 2 safeguarding training. Staff had a basic awareness of safeguarding but would refer any concerns to the pharmacists. Details about local safeguarding procedures and contact information for local safeguarding agencies was available.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy is currently increasing its staffing profile to improve its contingency arrangements and better manage its workload. The team members understand what they can and cannot do if there is no pharmacist present at the pharmacy. They can raise any concerns with the pharmacy owner. And they know when they need to refer queries to the pharmacist. The pharmacy provides its team members with some support in meeting their learning and development needs.

Inspector's evidence

The pharmacy had a small team who appeared to work very closely together. The owner was currently recruiting an additional trained dispenser to support the workload. He had recently recruited a new member of staff to help on the photographic counter. The rest of the team comprised a pharmacy technician, a trainee medicines counter assistant (MCA), and a delivery driver. Confirmation was received shortly after the inspection that the trainee MCA had been put on the appropriate accredited training for this role. On occasions, the trainee MCA also helped to put stock away in the dispensary and the owner was reminded about the training requirements for support staff involved in tasks in the dispensing process. The owner provided most of the responsible pharmacist cover and there was a locum who regularly worked at the pharmacy one day per week. The locum pharmacist was working at the start of the inspection and the pharmacy owner arrived soon after and remained onsite for the rest of the visit. The owner's wife occasionally worked at the pharmacy, completing largely administrative tasks. The range of services provided by the pharmacy was limited mainly to dispensing prescriptions and the team was coping with the workload during the inspection. People were acknowledged when they came into the pharmacy and the phone was answered promptly. As described in principle one, the owner had reviewed the pharmacy technician's hours to avoid self-checking of prescriptions as much as possible.

There was no formal review process, but staff said that the owner provided on-the-job feedback and coaching to them. The trainee MCA said she also read articles in trade publications to learn about new products or other healthcare matters. She explained that she would be comfortable asking any questions or raising any concerns with either the owner or the pharmacy technician. The owner explained that he and the pharmacy technician completed various training modules to meet the requirements for continuing professional development and revalidation with the GPhC. These included courses provided by the Centre for Pharmacy Postgraduate Education. The pharmacy technician was also due to attend refresher training about healthy living. Both regular pharmacists had completed the practical and theory training required to provide seasonal flu vaccinations.

When asked, the trainee medicines counter assistant was able to describe the types of questions she asked before selling medicines, to make sure the medicines were appropriate for people to take. She explained that she referred all requests for pharmacy medicines or healthcare advice to the pharmacist to make sure the sale or information provided was appropriate. She also understood what she could and couldn't do if there was no pharmacist present.

The team members worked closely together and were seen to discuss queries with each other throughout the visit. The owner explained that his main focus was patient care. He gave examples of referring prescription queries to prescribers and assessing the appropriateness of providing medicines

in multi-compartment compliance packs or offering alternatives to meet people's individual needs. There were no targets set for pharmacy services.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy's premises are safe and appropriate for the services it provides. They can be protected against unauthorised access.

Inspector's evidence

At the front of the shop was a photographic counter and the medicines counter and dispensary were towards the rear of the premises. The premises were bright and clean and presented a professional image to members of the public and they were lockable. Staff shared responsibility for cleaning. The room temperature was appropriate for storing medicines. And there was good lighting for dispensing activities. The entrance door was wide enough to accommodate wheelchairs and prams and there was level access into the shop from the street. Staff hygiene facilities were clean. There was soap and hot and cold running water for handwashing.

The dispensary was relatively small but was laid out in an organised manner. Some parts of the dispensary were designated for specific tasks such as dispensing multi-compartment compliance packs and completing accuracy checks of prescriptions. This was to reduce risks during the dispensing process. There was adequate dispensing bench space for the workload. The dispensary was clearly separated from the retail area and was not readily accessible to people visiting the pharmacy. The pharmacist generally stood at a workbench just behind the medicines counter so was able to supervise any medicines sales or requests for advice closely. There was an alert bell at the entrance which let staff know if people had come into the shop and there was generally a member of staff in the shop to assist customers. Prescriptions waiting collection were stored in a designated area away from the counter meaning that medicines and people's information was protected. Pharmacy-only medicines were stored behind the counter to prevent self-selection. Medicines for dispensing were stored off the floor.

There was a consultation room to the side of the medicines counter. This room was signposted and was suitable for providing services which needed greater privacy. The entrance to the room from the shop floor could be locked. Details of the pharmacy's chaperone policy were displayed for people using the room. A large window at the side of the room had a blind which could be drawn when necessary. There was also a small window in the door which faced onto the shop floor. The owner was aware of the need to consider people's privacy if they had to remove items of clothing for services such as vaccinations. He would obscure the view into the room if needed. There was seating and a table in the room. The owner explained that he intended to reinstate access to the patient medication record system in the room once the new system was installed.

Principle 4 - Services ✔ Standards met

Summary findings

Overall, the pharmacy's services are undertaken safely and effectively. The pharmacy gets its medicines from reputable sources and it stores them and other stock appropriately. It takes the right action in response to medicine recalls and safety alerts to protect people's health and well-being. The pharmacy supplies medicines in multi-compartment compliance packs in an organised way. And the pharmacist considers the individual needs of new patients when deciding if this service or another type of support is the best way to help people to take their medicines at the right times.

Inspector's evidence

There were notices displayed in the pharmacy about the services it provided or other sources of support for people. The pharmacy's opening hours were displayed at the entrance. The pharmacy's practice leaflet was also available, and this gave more information about the pharmacy including information for people about how to raise a complaint.

Dispensing was undertaken in an organised manner. Baskets 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. Prescription forms were kept with dispensed medicines so could be referred to when people came to collect their medicines. Some people received their medicines in multi-compartment compliance packs. The owner explained how requests for this service originated from GPs, carers and patients, and was sometimes suggested by the pharmacy. Alternatives such as providing medicine administration charts were also offered by the pharmacy to help people to remember to take their medicines at the right times. The compliance packs were prepared in a designated area of the dispensary. Prescriptions were ordered on behalf of people and missing items or unexpected changes were queried with the person or their GP. There were no prepared packs available to look at during the inspection. There was some evidence that details about interventions or changes had been added to people's records so could be referred to in future. Package information leaflets were provided with the packs every four weeks. The owner explained the types of medicines they generally wouldn't put in the compliance packs, for example, medicines with varying doses or medicines which were hygroscopic. There was a process to retrieve and reissue new packs if changes were made to people's medication mid-cycle. This meant that, wherever possible, people did not have obsolete packs in their possession which could lead to medication errors.

The owner was aware of the need to provide information about pregnancy prevention to people in the at-risk group who were supplied valproate-containing medicines. The pharmacy had warning stickers to apply to dispensed medicines and patient safety literature to hand out to people. The owner explained how he tried to make sure warnings on original packs were not obscured when dispensing labels were attached though this could be hard at times. The pharmacy made checks to make sure that people taking warfarin were being monitored appropriately. These checks were not generally recorded. So, this information may not be readily available to pharmacists in the event of future queries. Alert stickers were applied to dispensed prescriptions for controlled drugs so checks could be made to ensure the medicines weren't supplied when the prescription was no longer valid.

The pharmacists had completed the necessary 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. Sharps waste was stored safely. And the pharmacy had adrenaline auto-injectors available to use in the event of anaphylaxis reactions. The pharmacy kept a record of the prescriptions that were delivered to people. The records seen showed that most recipients signed the record themselves with only a few signed on their behalf by the driver. Those medicines that required additional care were highlighted to the driver, including medicines that needed to be refrigerated.

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. The pharmacy used dividers to separate some medicines, particularly those where the packs looked very similar and to separate different strengths of medicines more clearly. One example highlighted by the owner was two pack sizes of indapamide 2.5mg tablets which were identical in shape and appearance though one pack contained 28 tablets and the other 56. 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 liquids which had reduced shelf-lives once opened. No out-of-date medicines were found when stock was spot-checked. Medicines were kept 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 owner explained how the pharmacy had been trying to manage supply issues affecting medicines. This had involved contacting suppliers regularly for updates, advising people to return to their prescriber for an alternative if necessary, or contacting prescribers on behalf of patients when needed. The pharmacy was upgrading its patient medication record system and the new system would enable it to comply with the Falsified Medicines Directive (FMD). It had the right hardware in place for this. Appropriate arrangements were in place for storing CDs. There was enough storage capacity for medicines requiring refrigeration. The medicines fridge was 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 kept a clear audit trail to show it had received and acted on recent safety alerts and recalls.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy generally has the right equipment and facilities it needs for its services. It uses up-to-date information sources when providing advice or when making clinical checks. And it keeps people's personal information safe.

Inspector's evidence

The pharmacy had glass measuring cylinders of an appropriate standard for measuring liquids and these were clean. Electrical equipment appeared to be in good condition, and it was tested periodically to make sure it was safe. To help make sure advice to people and clinical checks were based on current information, the pharmacy had access to up-to-date reference sources in hard copy and online.

The team members used cordless handsets for phone calls so they could hold conversations out of earshot of people waiting in the shop. Personal information held on equipment in the pharmacy was stored out of sight and reach of the public. There were maintenance contracts in place for the alarm system to make sure it was operating correctly. The blood pressure meter used for ad hoc blood pressure checks was replaced each year to ensure the results provided to people were reliable.

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.