General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: West Street Pharmacy, 41A West Street, Congleton, Cheshire, CW12 1JN

Pharmacy reference: 1029591

Type of pharmacy: Community

Date of inspection: 01/07/2024

Pharmacy context

This is a pharmacy in the town centre of Congleton in Cheshire. It mainly dispenses NHS prescriptions and sells over-the-counter medicines. Some medicines, it dispenses into multi-compartment compliance packs to help people take their medicines properly. The pharmacy offers a number of services, including substance misuse services, NHS Pharmacy First and NHS Hypertension service. It delivers medicines to people at home.

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 suitably identifies and manages the risks with its services. And team members have relevant written procedures to help them work safely and consistently. They keep people's confidential information secure, and they help protect the welfare of vulnerable people using the pharmacy's services. They mostly keep accurate records as required by law. And team members record and learn from mistakes they make whilst dispensing.

Inspector's evidence

The pharmacy had a set of standard operating procedures (SOPs) relevant to its services. These included for dispensing, Responsible Pharmacist (RP) regulations and for the delivery of medicines to people's homes. The SOPs seen had a range of review dates, including dates just outside of the review date in February 2024 and another in June 2024. The current team members had signed a training record to confirm they had read the SOPs. Team members were seen following procedures, such as checking a person's name and address prior to handing out prescription medication. The correct RP notice was displayed, and people came into the pharmacy and asked for the pharmacist by name for advice. Team members, including the locum dispenser were aware of their roles and responsibilities. The locum dispenser was working their first day at the pharmacy and the pharmacist had clearly explained what the dispenser was expected to do and when to refer to the pharmacist.

Pharmacy team members recorded near miss errors on a paper record, with regular entries made each month. These errors were those identified before people received their medicines. When the pharmacist identified a mistake, this was discussed with the dispenser, and they were asked to find their own mistake to help their learning. The entries in the near miss record were basic, with little detail about the error recorded and the actions taken were recorded as 'correcting the mistake'. There were no formal patient safety reviews completed. The team had made changes to the layout of the shelves to help prevent selection errors such as for amlodipine and one dispenser described how they were extra vigilant when dispensing ramipril tablets and capsules following mistakes being made. The pharmacy took dispensing incidents seriously and shared these with the head office team. These were errors identified after the person had received their medication. The pharmacist described investigating what had happened and resolving the matter with the person. There were alerts made on people's patient medication records (PMR) both following errors and proactively to help prevent errors. This included highlighting two people with the same name, to alert the team to take care with their prescriptions.

There was a poster in the retail area and in the consultation room welcoming feedback, with a contact email address. The pharmacy had changed ownership approximately nine months ago and since then the pharmacist had actively sought to build relationships by attending meetings with the local surgery teams to help improve services. The local community social media page showed regular compliments for the services the pharmacy provided, and the pharmacist was mentioned by name for the help he had given to people.

The pharmacy had current professional indemnity insurance. Most of the records required by law were completed correctly. There were some inaccuracies in the electronic private prescription records checked, as the prescriber recorded was not the prescriber who had written the prescription. This resulted in a discussion with the pharmacist about selecting the correct prescriber on the system when

dispensing. There was a private prescription that had been dispensed but had not been signed by the prescriber. A sample of the electronic CD register entries checked were up to date and mostly complete, with checks of the physical stock against the register balance recorded at least every two weeks. The entries for the receipt of CDs did not record the complete address for the wholesaler. For two CDs checked, the physical stock was correct against the register balance. The records of destruction for people returning CDs that they no longer required were not all up to date and the importance of these records being accurate was discussed with the pharmacist. The paper RP record was completed correctly from the sample of entries checked, but as the dates were pre-printed on the form there was no space to accurately record a change of RP during the day. Unlicenced special records were complete with details of prescriber and patient.

Team members understood the importance of not sharing people's personal information and they stored confidential waste in sealed bags, which were collected by a third-party contractor for disposal. There was a visitor's sign in book, which protected people's details from being viewed when signing in. The pharmacy advertised a link to a privacy policy on its website, but the policy was not complete and there wasn't a privacy policy displayed in the pharmacy. The pharmacist had completed CPPE safeguarding training and team members had completed training as part of the NHS Pharmacy Quality Scheme. They described scenarios which would raise concerns about the welfare of a vulnerable person and how they would on every occasion refer to the pharmacist for help. There were no local safeguarding contact details displayed. The pharmacist described how concerns were reported to the company's head office so the right outcome for the person could be sought.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough suitably skilled team members to provide its services. And they work well together to manage the workload. Team members receive appropriate support to complete their training. And the pharmacist provides a good level of supervision to help them complete tasks within their capabilities. Team members feel comfortable suggesting ideas and discussing any concerns they may have to improve the way they work.

Inspector's evidence

The RP's role was that of full-time pharmacist manager, and they were also part-owner of the pharmacy. The pharmacy had changed ownership nine months previously. There was a trainee dispenser and a locum dispenser, who was a third-year pharmacy student working with the RP. There were another two employed trainee dispensers not at work. The pharmacist supervised the dispensers and allocated them tasks. The dispensers responded to people's queries and requests within their capability, promptly and competently. There were some opportunities for part-time team members to cover annual leave. The pharmacist, who organised staff cover, used a locum agency when needed to cover absences and holidays.

Team members were at various stages of their dispenser qualification training, and they completed most of the course outside of working hours. The dispenser felt supported and described how the pharmacist helped when they had questions about the course work. There were no formal ongoing training modules for staff outside of the accredited qualification training. The pharmacist supported the team with any additional learning, for example to learn about their role in new services. And the team had been trained to take people's blood pressure. It was the locum dispenser's first day working in the pharmacy and they had received a thorough induction about the pharmacy as they started their shift. They were seen confidently using the IT systems, the till and dispensing.

The team communicated with each other well, without holding formal team meetings. The pharmacist manager had not yet completed formal appraisals with team members but held more informal reviews with team members on a one-to-one basis. A dispenser described how they felt comfortable sharing ideas to improve services and gave examples of a change made regarding stock storage. They felt comfortable raising concerns with the pharmacist and with the head office team. There were contact details available for key people at head office and team members felt they would be listened to should they have concerns. The pharmacy had incentives, including for increasing prescription items, and taking people's blood pressure. Team members spoke about the targets in a positive way.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are secure, clean and provide a suitable space for the pharmacy's services. Team members use a suitably sized, private consultation room so people can have confidential conversations and access services.

Inspector's evidence

The pharmacy was on the corner of a street and had a curved front and facia, this meant that although the premises looked large from outside, there was a relatively small dispensary to the back of the retail area. The layout of the premises meant people did not attempt to access restricted areas. And it allowed the pharmacist to supervise sales of medicines and dispensing. There were additional areas off the dispensary including a long narrow corridor with the fire exit door at the end. The team stored stock and consumables there in a tidy and organised way keeping the main walk-through area clear. The staff facilities were clean and mostly uncluttered, with hot and cold water and other hand washing facilities. The pharmacy was hygienic and maintained to a reasonable standard. The company had a website which provided some information about services and opening hours of the pharmacy. There were details of how people could contact the company's head office. However, the website details were incomplete, for example there was no link to the GPhC registration details, the 'about us' section had not been completed and there were no details provided of the pharmacy superintendent. This meant people did not have access to useful details about the pharmacy and the company.

The pharmacy premises were sufficiently well lit and kept at a reasonable temperature for working and storing medicines. The pharmacy had a dispensary drawer system across one length of the dispensary, which helped ensure there was enough space to store its medicines. There was limited bench space, and some shelving was kept free to store baskets with prescriptions and medicines awaiting stock. This helped benches from becoming too cluttered. The consultation room was soundproofed and had frosted glass to allow light into the room whilst maintaining privacy. A sharps bins were stored on the side team members sat to protect people's safety.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy actively helps people in the local community access its services. And it manages and delivers its services safely and effectively. Team members obtain medicines from recognised sources. And they appropriately store and manage medicines as they should. They conduct regular checks to make sure medicines are suitable to supply.

Inspector's evidence

The pharmacy had a small step up from the pavement outside, and there was a portable ramp to help people, who needed it, access the premises. The pharmacy had leaflets about the pharmacy, its opening hours and services provided and a displayed a few other healthcare posters and leaflets to help people access services. Since the change of ownership, the pharmacist had engaged with the local surgeries, having had several meetings, to promote collaborative working in providing local healthcare services. The pharmacy was active on a local social media platform site, and regularly informed the local community about the services provided, such as the different treatments available through the NHS Pharmacy First Service. It had current patient group directions for the different treatment pathways for this service, signed by the regular pharmacist. The pharmacy provided the NHS hypertension service, and the pharmacist described how they electronically recorded the blood pressure readings, so the person's GP had access to the results. They provided lifestyle advice as part of the consultation. The pharmacy provided deliveries to people's homes. It kept a list of people it was delivering to, to help resolve queries and the driver obtained signatures for deliveries involving controlled drugs.

Team members helped reduce the risk of errors when dispensing by using baskets, to keep people's medicines and prescriptions together. And they used stickers to highlight medicines requiring storage in a fridge and for CDs. Team members signed the dispensing labels to take responsibility for who had dispensed and checked the medicine. There were different areas of the dispensary for dispensing and checking prescriptions, and dispensing of medicines into multi-compartment compliance packs was kept separate. The compliance packs were stored in an organised and logical manner in a separate area of the dispensary. The dispenser ordered these prescriptions in good time to allow for the resolution of queries and so people received their medicines when they needed them. The records of the person's current medication and administration times was recorded on the person's patient medication record (PMR) and changes in medication were recorded there. The pharmacy supplied patient information leaflets once a month and the dispenser annotated the packs with information about what individual medicines looked like, to help identify them should there be any queries. Team members were aware of the requirement to dispense valproate in the original manufacturer's pack. They had assessed the risks of dispensing valproate into compliance packs and adjusted one person's dispensing regime as a result. The pharmacist was aware of their responsibilities in dispensing and providing counselling to people taking valproate who may become pregnant and supplying the patient card. The pharmacy provided substance misuse services, including supplying daily doses of medicines in individual bottles. It was part of the local authority programme to supply injecting equipment. The pharmacist had contacted the local substance misuse team to understand the need in the local community. They had assessed how many people they could dispense these medicines for safely and limited the number of people accessing the service accordingly.

The pharmacy obtained medicines from recognised wholesalers. Pharmacy-only (P) medicines were

displayed behind plastic screens close to the medicines counter. Notices on these screens instructed people to ask for help in accessing the medicines. A team member explained in detail the process for checking the expiry dates of medicines, but there were no up-to-date records of the checks made to refer to. Stickers were used when medicines with a short expiry date were identified, so these medicines could be used first or removed in the month they expired. All medicines checked were found to be in-date. There were three medical fridges, and records were completed daily and showed temperatures to be within the required range. The fridges showed correct temperatures during the inspection. Internal thermometers were used to record and monitor the temperatures as the team was unsure how to operate the in-built settings. The pharmacy stored people's returned medicines in pharmaceutical waste containers until a third-party contractor collected them. They were stored neatly away from stock in the dispensary. There was a large stock of CD destruction kits, used to denature unwanted CDs returned by people. The pharmacy team printed a copy of medicine recalls it received, and the pharmacist signed and dated the sheet with the action taken. Recently actioned recall sheets were seen stored in a file.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

Team members have access to the equipment they need to provide the pharmacy's services. And they use the equipment appropriately to protect people's confidentiality.

Inspector's evidence

The pharmacy had equipment available for the services provided, which for dispensing included a range of sizes of glass measures for liquids. It had disposable consumables for the dispensing of medicines in compliance packs and these were stored in a clean, dry area of the pharmacy. There was a blood pressure monitor in the consultation room, which appeared in good condition and was replaced regularly by the pharmacy's head office. The pharmacist reported the weighing scales were measuring accurately, but they had not been professionally calibrated in the last nine months since the change of ownership. The team had access to reference resources and the internet to obtain up-to-date information to help with their work and to answer queries.

The computer screens, showing people's confidential information, were positioned away from unauthorised view. The computers were password protected and team members had their own NHS smart cards. These cards restricted access to people's summary care records (SCR) according to role. The team was observed gaining consent before accessing a person's SCR. Medicines awaiting collection were stored in the dispensary to make sure people's confidential information on prescriptions and name and address labels were not on public view.

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.