General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Hollowood Chemists Ltd, 143 West Street, CREWE, Cheshire, CW1 3HH

Pharmacy reference: 1029619

Type of pharmacy: Community

Date of inspection: 13/06/2023

Pharmacy context

The pharmacy is located on a busy main road in a residential area and is next to a medical centre. NHS dispensing is the main activity, mainly for patients of the medical centre. The pharmacy also provides a number of other NHS services and sells a range of over-the-counter medicines. It supplies medicines in multi-compartment compliance aids (MDS) for some people, to help them take them at the right times. Most MDS dispensing is done off-site at a hub pharmacy. The pharmacy also provides a covid vaccination service from associated premises across the road.

Overall inspection outcome

Standards not all met

Required Action: Improvement Action Plan

Follow this link to find out what the inspections possible outcomes mean

Summary of notable practice for each principle

Principle	Principle finding	Exception standard reference	Notable practice	Why
1. Governance	Standards not all met	1.1	Standard not met	Members of the team are unclear about some of the pharmacy's procedures and there is no evidence that they have read SOPs.
		1.6	Standard not met	The CD records are inaccurate and unreliable. The responsible pharmacist record is incomplete. Unlicensed specials records are incomplete and disorganised.
2. Staff	Standards not all met	2.3	Standard not met	There is a lack of professional leadership to provide assurance that the team is operating safely and effectively
3. Premises	Standards met	N/A	N/A	N/A
4. Services, including medicines management	Standards not all met	4.3	Standard not met	Controlled drugs are not always stored appropriately.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance **Standards not all met**

Summary findings

The pharmacy does not always effectively manage the risks associated with its services. It has written instructions to explain how services should be provided. But members of the team have not read all of the instructions so they may not always work safely or effectively. And they do not record things that go wrong so they may not always be able to learn from them. The pharmacy keeps the records that are needed by law. But some of its records are incomplete or inaccurate. So the team cannot always show whether services are being provided effectively.

Inspector's evidence

The pharmacy had a full set of written standard operating procedures (SOPs) that were dated to show they had been introduced in 2018. Members of the dispensing team were unsure whether these were the current SOPs. They thought newer versions may be available online, but they were unable to find them. There were no training records for the SOPs. And although team members did remember reading some SOPs, they did not know when or which ones they had read.

A responsible pharmacist (RP) notice was prominently displayed at the medicines counter. When questioned, team members were able to describe their roles and responsibilities. And dispensing labels were initialled by dispenser and checker to provide an audit trail. The pharmacy did not advertise a complaints procedure, but the team said that if people raised concerns, they were normally able to resolve them in branch. If not, they would be reported to the superintendent pharmacist (SI).

The RP was a locum but worked at the pharmacy fairly regularly, usually about two days a week. He explained that dispensing errors could be recorded on the pharmacy computer and showed examples of records he had made in the past. He did not know whether other pharmacists recorded errors in the same way, or whether it was the expected procedure. The records included action to be taken to avoid the errors being repeated – for example, by separating quinine and quetiapine on the dispensary shelves. The pharmacy did not keep any records of near-miss incidents. The dispensers confirmed that they were normally made aware of any mistakes they made and that they sometimes discussed them as a team to learn from them.

An electronic controlled drugs (CD) register was in use and appeared to be up to date. Running balances were recorded but no balance checks had been recorded for just over a year. A random selection of balances were checked against stock and several discrepancies were identified. Patient returned CDs were recorded separately in a paper register and the records appeared to be up to date. RP records were held on the pharmacy computer but there were a number of days where no record had been made, for example, no RP was recorded for 25 May, 27 May, or 8, 9, 10 June. For the records that had been made, the start times had been recorded, but very few included the time that the RP had finished. Records of private prescriptions and emergency supplies appeared to be in order. Records of unlicensed specials were kept in a box file, mixed amongst private prescription forms and other documents, so they were difficult to locate. One certificate of conformity was found but it did not include details of the patient or the date of supply. This meant that the pharmacy would not have a complete audit trail in the event of a query or concern.

The dispensers did not remember doing any specific training about information governance but said it had been covered in their dispenser training courses. When questioned, they understood the need to protect confidential information. A shredder was used to destroy confidential waste, which a dispenser described as ‘anything that included a patient name’.

The pharmacist confirmed he had completed level 3 safeguarding training, because he had worked as a vaccinator for children. The dispensers had not completed any specific training but knew they should speak to the pharmacist if they had any concerns about vulnerable people.

Principle 2 - Staffing **Standards not all met**

Summary findings

There are enough staff to manage the workload. Members of the team receive the training they need for the jobs they do. They work well together and seem confident carrying out routine activities. But they lack leadership, so they do not always work effectively or properly understand what is expected of them.

Inspector's evidence

The pharmacy had not had a regular pharmacist for more than a year and various locum pharmacists worked as RP. At the time of inspection, the RP was supported by three dispensers. One of the dispensers had just completed her mandatory training and the other two were still undergoing training. The pharmacy also employed a part-time pharmacy technician, who normally worked in the afternoons and worked as an accuracy checker (ACT). A part-time medicine counter assistant worked on Fridays and Saturdays. During the inspection, the pharmacy team was kept busy but appeared to be able to manage the workload.

The team worked well together and seemed comfortable dealing with customers, selling medicines and carrying out the routine dispensing activities. But, when questioned, members of the team were generally unsure about the governance arrangements that were supposed to be in place, such as SOPs, error records, record keeping and CD balance checks. The dispensers said that the ACT was normally responsible for that sort of thing and might have more idea what happened and what the procedures were supposed to be.

One of the trainee dispensers was mainly covering the medicines counter. They appeared to deal with medicine sales confidently and were seen asking the pharmacist for advice when needed. The team was aware that some medicines could be misused but were not aware of any requests for regular repeat sales. Team members thought sales of over-the-counter medicines were generally low.

Members of the team did not know whether the pharmacy had a whistleblowing policy in place. But they knew how to contact head office and said they would do so if they had any concerns that they didn’t want to raise in the branch. Some performance targets were set, including for blood pressure checks, but that the team did not feel under pressure to meet them.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean and tidy, and it provides a suitable environment for healthcare. The dispensary is well organised, and a consultation room is used when people need privacy.

Inspector's evidence

The pharmacy was clean and tidy. There were two entrances, at the front and rear, and the medicines counter spread around the perimeter of the dispensary so that people could approach from either side. Perspex screens had been fitted to protect against viral transmission.

There were two consultation rooms. One could be entered directly from the dispensary and housed an automated methadone measuring system. The pharmacist explained that room was not normally in use for consultations so people used the other room which was located at the rear of the retail area. The second room was clean and tidy and appropriately equipped.

There was sufficient clear bench space in the dispensary to allow safe working. There was a small stock room at the rear of the dispensary and further stock rooms upstairs. Toilet facilities were also available upstairs and they were clean and tidy.

There was a dispensary sink fitted with hot and cold water. Air conditioning was fitted, and all parts of the pharmacy were well lit. The entrances to the pharmacy were lockable and doors and windows were protected with shutters.

Principle 4 - Services **Standards not all met**

Summary findings

The pharmacy provides a range of services that are easy to access and the dispensing operation is generally well organised. Stock medicines are obtained from licensed suppliers and the team carries out some checks to make sure they are in good condition. But checks are not always recorded so the team members cannot show what they have done. And controlled drugs are not always stored appropriately.

Inspector's evidence

The pharmacy had two entrances, one at the front and one at the back, which was closer to the medical centre. The rear entrance had a small step, but the front entrance was level and had an automatic door that was suitable for wheelchairs. There was a notice in the pharmacy window identifying the services that were available and some further information about them was provided in leaflets and posters inside. Opening hours were also prominently displayed.

The pharmacy offered a delivery service. The driver explained that they used a hand-held electronic device to manage the deliveries and keep a record. They got signatures on the device from some people, but a lot of people found it too difficult to sign. If people were not home to receive the delivery, the driver left a note and returned the medicines to the pharmacy.

Dispensing baskets were used to keep individual prescriptions separate and avoid medicines being mixed up during dispensing. The RP confirmed that prescriptions were always clinically checked by a pharmacist before the ACT was allowed to accuracy check. He explained that he always initialled the prescription form to confirm he had completed the check. But he knew from speaking to the ACT that other pharmacists did not always do that and would just tell her which prescriptions they had checked.

Medicines that were supplied in MDS trays were mostly assembled offsite at a hub pharmacy that used a dispensing robot. Prescriptions for the hub were clinically checked at the pharmacy. The labelling information was then transmitted to the hub for them to assemble the MDS. The dispensed medicines were then accuracy checked at the hub and returned to the pharmacy in sealed bags for handout to patients. The RP said the bags were then supposed to be handed out without any further checks. But he felt uncomfortable with that so always opened the bag and carried out another accuracy check. He realised that this meant he would be taking the responsibility back from the hub pharmacist. The MDS were labelled with QR codes that could be scanned to provide the relevant patient information leaflets. However, printed leaflets were not provided so patients unable to scan the QR code may not receive all of the information they may need. The pharmacy still dispensed some MDS on site, if they were not suitable to send to the hub – for example, if the prescription included a CD or fridge line.

Dispensed medicines awaiting collection were bagged and kept on dedicated shelves. Stickers were attached when CDs were included so that the team could check the prescription was still valid when the medicines were handed out. But the team did not routinely highlight medicines such as warfarin or lithium, so the RP would not always know when they were being handed out so they could decide whether counselling was needed. The team were heard confirming names and addresses before medicines were handed out, to make sure they were being given to the right person. Owing slips were used to provide an audit trail for any medicines that could not be immediately supplied.

The RP was aware of the risks associated with the use of valproate during pregnancy and confirmed they would counsel patients when they were handed out. Valproate was normally supplied in original packs which included all necessary information. The team members remembered seeing extra educational material. But they did not know where it was kept, so might not be able to provide it if it was needed.

The pharmacy obtained its medicines from licensed wholesalers and unlicensed specials were ordered from a specials manufacturer. No extemporaneous dispensing was carried out. Stock medicines were stored tidily on the dispensary shelves. The dispensary stock was divided into sections and members of the team were each given responsibility for one section. They were then expected to carry out regular expiry date checks of medicines in their section. A record chart was available for each section, for the team member to record dates when checks had been completed. One chart showed checks had last been completed in February for that section and the dispenser explained they were just about to start again. There were no records for another section, but the dispenser stated that the stock had been checked recently and that they had forgotten to make the record. A random selection of stock was checked and no expired medicines were found.

There were two fridges being used to store medicines and both were equipped with maximum/minimum thermometers. Both fridges appeared to be working correctly, but the pharmacy team was not regularly checking the thermometers so might not be aware if there was a malfunction. A record chart was kept for one fridge, but the last recorded check was in April. No records were available for the other fridge.

CDs were being stored in two cupboards. Both cupboards were very full which made it difficult to keep them tidy. One of the cupboards was not appropriate for the storage of CDs. Patient returned CDs were appropriately segregated pending destruction. Waste medicines were disposed of in dedicated bins that were collected periodically by a specialist waste contractor.

Drug alerts were received by e-mail from the MHRA and from the company head office. Most of the emails received since January were still unopened, which meant important messages might not have been read. However, the RP explained that details of drug alerts were also always sent to the RP by Whatsapp from head office, and they were expected to respond the same day to confirm they had been actioned. The RP produced a Whatsapp message on his phone as an example. But no other records were kept so the pharmacy could not demonstrate whether all alerts had been dealt with appropriately.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

Members of the pharmacy team have the equipment and facilities they need for the services they provide. Equipment is appropriately maintained so that it is safe to use, and it is used in a way that protects privacy.

Inspector's evidence

The pharmacy had various reference books, including recent editions of the BNF and the team could also access the internet for the BNF and for general information. A range of crown stamped measures were used to measure liquids. They were clean and stored appropriately. An automated pump was used to measure methadone. The RP confirmed that the methadone mixture was stored in the CD cupboard overnight and that the machine was cleaned and calibrated each morning.

Electrical equipment appeared to be in good working order and stickers showed that PAT testing had been carried out in 2020. A blood pressure meter was in use but there was no record of calibration or how long the machine had been in use. So the pharmacy could not provide assurance that the results were reliable.

The dispensary was screened to provide privacy for the dispensing operation. The consultation room was used for services that required privacy and for confidential conversations and counselling. A cordless phone was available so that phone calls could be made without being overheard. Pharmacy computer screens were positioned so that they were not visible to the public.

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.