General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Dean & Smedley Ltd, 91 High Street, Measham, SWADLINCOTE, Derbyshire, DE12 7HZ

Pharmacy reference: 1030462

Type of pharmacy: Community

Date of inspection: 21/03/2024

Pharmacy context

The pharmacy is located in a row of shops in a village. The pharmacy dispenses NHS prescriptions and supplies some people with medicines in multi-compartment compliance packs to help them manage their medicines. It also provides a seasonal flu vaccination service, the NHS Pharmacy First service and a blood pressure check service.

Overall inspection outcome

✔ **Standards met**

Required Action: None

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 met	1.2	Good practice	The pharmacy is good at recording and reviewing mistakes that happen during the dispensing process. And it uses this information to help make its services safer and reduce any future risk.
		1.8	Good practice	The pharmacy team memebers have undertaken appropriate safeguarding training and are able to describe actions they have taken to safeguard vulnerable individuals.
2. Staff	Standards met	2.4	Good practice	The pharmacy has a culture of openness, honesty and learning.
3. Premises	Standards met	N/A	N/A	N/A
4. Services, including medicines management	Standards met	4.1	Good practice	The pharmacy provides a range of services and takes steps to make sure people can use them.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance ✔ Standards met

Summary findings

The pharmacy is good at recording and regularly reviewing any mistakes that happen during the dispensing process. And it uses this information to help minimise any future risks and help make its services safer. Its team members understand their role in protecting vulnerable people. The pharmacy regularly seeks feedback from people who use the pharmacy. And it keeps its records up to date and in line with requirements.

Inspector's evidence

Standard operating procedures (SOPs) were sent by head office electronically. These were printed out and team members were provided with time to read through the SOPs. Any new SOPs received were usually read and implemented within three days of receiving them. Updated words or sections in SOPs were highlighted in red to draw team members attention to the change. There were some branch specific SOPs. Relief staff were emailed a copy of SOPs including any updates. Responsibilities were listed on all SOPs and the cover sheet showed who each SOP was relevant to.

Dispensing mistakes which were identified before a medicine was supplied to people (near misses) were highlighted to the team member involved in the dispensing process and were discussed with the team and these were then recorded. A detailed account of what happened was recorded. Team members recognised that this was the only way to learn from mistakes. When a dispensing mistake happened and the medicine had been supplied (dispensing error), the team explained that the error would be investigated and an incident record form including a root cause analysis was completed. A copy of the completed form was sent to head office who would contact the team if any additional action was required. A patient safety review was completed each month. This was done by a different team member each month to get a different perspective. The reviews looked at near misses, dispensing errors, complaints, and drug safety alerts. It also looked at the action points from the previous month's review. The review was read by and discussed with all team members. As a result of past reviews amitriptyline and amlodipine had been separated on the shelves. Team members also described how they had memorable words to associate with specific medicines that they most commonly made mistakes with. For example, the dispenser had a memorable word that she used each time she had to dispense ramipril and, since starting this method, hadn't made any mistakes between the tablets and capsules.

The pharmacy received a weekly newsletter from head office which was read by all team members. This covered any training that needed to be completed and had learning from errors that may have occurred in other branches. Recently, there had been information about the change in pack size of digoxin from 28 tablets to 30 tablets as there had been a pattern of errors picked up. In addition to this, bulletins were also received for product recalls and any changes in legislation or guidance.

The correct Responsible Pharmacist (RP) notice was displayed. When questioned, team members were aware of the tasks that could and could not be carried out in the absence of the RP. The pharmacy had current professional indemnity insurance. A complaints procedure was in place and a notice was displayed in the retail area which gave people information on the complaints procedure. The team would try and resolve complaints in store where possible or refer to head office. People were generally happy with the service they received. There had been some feedback about medicines that were out of

stock, but team members explained they would try their best to source an alternative where possible.

Private prescription records, emergency supply records, RP records, records for unlicensed medicines supplied, and controlled drug (CD) registers were well maintained. Running balances for CDs were recorded and regularly checked against physical stock held in the pharmacy. A random balance was checked and found to be correct. CDs that people had returned were recorded in a register and appropriately destroyed.

Assembled prescriptions which were ready to collect were not visible to people using the pharmacy. The pharmacy had an information governance policy available, and its team members had all completed training about it. The pharmacy stored confidential information securely and separated confidential waste which was collected and taken to head office for destruction. The RP had access to summary care records (SCR) and obtained verbal consent from people before accessing it.

Team members, including the delivery driver, had all completed safeguarding training and read the relevant SOP. In the event that the delivery driver had any concerns he contacted the pharmacy and would speak to the RP. Team members gave an example where the driver had contacted the emergency services and the pharmacy when he had encountered someone who had fallen. Team members described another incident where they had contacted emergency services when they had received information of someone having taken an overdose. They also described how they had used the 'ask for Ani' scheme. Contact details for local safeguarding boards were available in the SOPs and also on the intranet.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy is good at helping staff keep their knowledge and skills up to date. Team members get regular feedback and they are supported when doing accredited courses. The pharmacy has enough trained staff to provide its services effectively.

Inspector's evidence

The pharmacy team comprised of the RP (a relief pharmacist), a pharmacy technician, a relief checking dispenser, a trainee dispenser and a trained medicines counter assistant (MCA). The pharmacy also had a delivery driver. Other team members who were not present included a pharmacy technician, a checking technician, the pharmacy manager and a trainee dispenser. The team members felt there was enough staff to manage the workload safely. They felt that they worked well together and were observed to be up to date with the workload.

Team members asked appropriate questions and provided advice to people before recommending over-the-counter medicines. They were aware of the maximum quantities of medicines that could be sold over the counter. And they referred to the pharmacist if unsure.

Team members had annual appraisals with the pharmacy manager and feedback was also given on an ongoing basis. Team members described that the pharmacy manger was approachable as was the head office team.

Team members completing formal training were well supported and were given set-aside study time. To keep up to date, team members completed training online and representatives from different manufacturers visited from time to time to provide information on products. Head office sent a summary of training which needed to be completed by all team members and once the training module had been completed a record was made. Team members were provided with time where possible to complete training at work. The newsletter sent from head office also contained training material. Team members who were required to complete continuing professional development training were provided with help by the pharmacy manager. The company held biannual whole staff meetings which included face-to-face training. Team members had attended a meeting a few weeks before the inspection. Training provided at the meeting had included: blood pressure measurements, Pharmacy First, cashing up, and dispensing etiquette. There was also training about eye drops and pain relief.

Meetings were held on a quarterly basis, chaired by a different team member. An agenda was drawn up and any issues were discussed. Pharmacists also attended periodic meetings at head office. The last meeting had covered the Pharmacy First service. Targets were in place for services provided and teams were encouraged to provide services. Team members said there was no pressure to meet the targets. Some of the targets were linked to the bonus scheme. The RP confirmed that they did not allow the targets to compromise their professional judgement.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy's premises are clean, secure and provide a safe environment to deliver its services. People using the pharmacy can have a conversation with its team members in a private area.

Inspector's evidence

The premises were clean, tidy, and organised. Areas of the dispensary had been allocated for certain tasks to help with the workflow. A separate area was used to prepare multi-compartment compliance packs. A clean sink was available for reconstituting medicines before they were supplied to people. Cleaning was done by members of the team in accordance with a rota. The room temperature and lighting were appropriate. The premises were kept secure from unauthorised access. A clean, signposted consultation room was available and suitable for private conversations. The pharmacy was due to undergo a refit in the summer.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy takes steps to ensure that people with a wide range of needs can access its services. It provides its services safely and manages them well. The pharmacy highlights prescriptions for higher-risk medicines so that there is an opportunity to speak with people when they collect these medicines. The pharmacy gets its medicines from reputable suppliers and stores them properly. It responds appropriately to drug alerts and product recalls. This helps make sure that its medicines and devices are safe for people to use

Inspector's evidence

The pharmacy was easily accessible from the street, with a ramp at the entrance. The shop floor was clear of any trip hazards and the retail area was accessed easily. Team members assisted people who needed help entering the pharmacy. Team members were familiar with any additional needs of regular customers and helped them to ensure they could access the services provided. A webcam was available and was used for services such as Pharmacy First if people were unable to come to the pharmacy in person. Team members described not covering the braille on medicine packs for certain people. In the past, the team had drawn pictures on the dispensing label to help a person identify what each medication was for. For example, a heart for heart medication and a neck for thyroid medication. People with severe allergies had flash notes added on their electronic record, a copy of this was printed and kept with the prescription. Any new medicines were checked with the person or their representative before being supplied. Team members used translation applications to help if someone did not speak English and they had previously used a Polish dictionary. The team also had a named contact who could assist with translating for some people.

Services were advertised using posters and leaflets displayed within the pharmacy. The pharmacy team members were familiar with other services provided locally and also had leaflets that they could hand out. The dispenser showed the NPA magazine which was given to people. She described how she marked articles which were relevant such as a recent one about the prepayment certificate. People who might be eligible were signposted to the magazine article.

Team members felt the Pharmacy First service had the most positive impact on the local population. The RP described that it was well accepted, and many people had self-referred themselves to the service after hearing about the service in the media. Prior to the launch of the Pharmacy First service, pharmacists had attended a meeting at head office and been briefed on the service. The company had some pharmacists who were providing the ear wax removal service and trained their colleagues on using the otoscope. Head office had created a folder for the service and a signed patient group direction (PGD) was kept in store. Email referrals were sent from the local surgery and others were received via PharmaOutcomes.

Flu vaccinations were also popular, and the regular pharmacist usually held clinics with back-to-back bookings.

The regular RP had created a form to hand to people if they needed to be referred back to the GP. The

RP described how she had referred someone the previous day with an infected nail bed, and they had come back two hours later with a prescription for antibiotics.

The pharmacy had an established workflow in place. Prescriptions were processed, labelled and clinically checked by the RP. Once the prescription was clinically checked the RP initialled the bottom right corner of the form. These were then passed to the dispensers who would dispense and pass on for checking by the accuracy checker. Warning tags were attached to prescriptions by the dispensers. There were separate tags for fridge lines, CDs (annotated with the prescription expiry date), if the person needed to be counselled, or if the dispensed medications contained warfarin. For warfarin, the INR was checked and recorded on the person's electronic record.

'Dispensed-by' and 'checked-by' boxes were routinely signed on dispensing labels, to create an audit trail showing who had carried out each of these tasks. Head office had a list of everyone's checking initials. In the event that a prescription was labelled by a team member and not the RP they also signed the prescription form. A separate box was used to store any prescriptions that had not been clinically checked. Baskets were used to separate prescriptions, preventing transfer of medicines between different people.

The RP was aware of the guidance for dispensing sodium valproate and the associated Pregnancy Prevention Programme (PPP). Team members were aware of the need to dispense sodium valproate in its original pack and ensure any warnings were not covered with labels. Posters were displayed in the dispensary and a risk assessment had been completed for someone who was supplied with sodium valproate in a compliance pack. Additional checks were carried out when people were supplied with medicines which required ongoing monitoring.

Some people's medicines were supplied in multi-compartment compliance packs to help them take their medicines at the right time. Individual records were kept for each person and detailed all their current medicines and any notes regarding changes. The pharmacy received a discharge summary following a person's stay in hospital. The discharge summary was reviewed, and changes to medicines were confirmed with the person's GP. Prescriptions were ordered by the pharmacy. Any other changes were checked and confirmed with the surgery. Prescriptions were labelled and clinically checked, and packs were prepared by the dispensers and checked by the accuracy checker or RP. Assembled packs seen were labelled with product descriptions and mandatory warnings. Information leaflets were supplied monthly.

The pharmacy's medicine delivery service was provided by a designated driver. If someone was not home, medicines were returned to the pharmacy and delivery was reattempted. Signatures were obtained for all medicines delivered.

Medicines were obtained from licensed wholesalers and were stored appropriately. Medicines were stored on the shelves, in a tidy and organised manner. Fridge temperatures were monitored daily and recorded; they were within the required range for the storage of cold chain medicines. And CDs were kept securely. Expiry date checks were completed by the team every six months. Short-dated stock was marked with stickers and recorded. A date checking matrix was available. No date-expired medicines were found on the shelves checked. Obsolete medicines were disposed of in appropriate containers which were kept separate from stock and collected by a licensed waste carrier. MHRA drug recalls were received via email, these were discussed with the team and actioned. A copy of the recall was kept in a folder.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide its services. Equipment is kept clean and is ready to use.

Inspector's evidence

The pharmacy had calibrated glass measures and tablet counting equipment. Separate labelled measures were used for liquid CDs to avoid contamination. Equipment was clean and ready for use. Two medical fridges were available. A blood pressure monitor, thermometer and an otoscope were available and used for some of the services provided; team members said the blood pressure monitor was sent to head office for calibration. Up-to-date reference sources were available.

The pharmacy's computers were password protected and screens faced away from people using the pharmacy. A cordless telephone was also available to ensure conversations could not be overheard.

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.