General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Shadforth Pharmaceutical Co. Ltd., 253 Broomfield Road, CHELMSFORD, Essex, CM1 4DP

Pharmacy reference: 1031063

Type of pharmacy: Community

Date of inspection: 07/06/2023

Pharmacy context

The pharmacy is located on a parade of shops in a largely residential area. It provides NHS dispensing services and receives most of its prescriptions electronically. It also provides a range of other services, including the New Medicine Service, blood pressure checks, flu vaccinations, and health checks. And it provides medicines as part of the Community Pharmacist Consultation Service. The pharmacy supplies medications in multi-compartment compliance packs to a few people who live in their own homes to help them manage their medicines.

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 adequately identifies and manages the risks associated with its services to help provide them safely. It records and regularly reviews any mistakes that happen during the dispensing process. It keeps its records up to date and accurate. Team members understand their role in protecting vulnerable people. The pharmacy largely protects people's personal information.

Inspector's evidence

The pharmacy had standard operating procedures (SOPs) and team members had signed to show that they had read, understood, and agreed to follow the SOPs. A mistake made during the dispensing process and identified before being handed out (known as a near miss), would be passed to the team member who had made the mistake at the time of the incident. The team member was then responsible for identifying and rectifying their own mistake. Near misses were recorded and reviewed regularly for any patterns. And items in similar packaging or with similar names were separated where possible to help minimise the chance of the wrong medicine being selected. The pharmacist explained how the pharmacy dealt with dispensing errors, where a dispensing mistake had reached a person. A recent error had occurred where the wrong strength of medicine had been supplied to a person. The pharmacy's head office was informed, and a root cause analysis was undertaken.

Baskets were used to minimise the risk of medicines being transferred to a different prescription. The team members signed the dispensing label when they dispensed and checked each item to show who had completed these tasks. There was an organised workflow which helped staff to prioritise tasks and manage the workload. And workspace in the dispensary was free from clutter.

Team members' roles and responsibilities were specified in the SOPs. The pharmacy manager said that the pharmacy would remain closed if the pharmacist had not turned up in the morning. She said that people would be informed that there was no pharmacist, and they would be signposted to another local pharmacy where needed. She knew which tasks could be carried out if there was no responsible pharmacist (RP) signed in, or if they were signed in but not in the pharmacy.

The pharmacy had current professional indemnity and public liability insurance. The private prescription records were completed correctly. The nature of the emergency was not routinely recorded when a supply of a prescription-only medicine was supplied in an emergency without a prescription. The RP said that he would ensure that this was recorded in future. There were signed in-date patient group directions available for the relevant services offered. Controlled drug (CD) registers examined were filled in correctly, and the CD running balances were checked at regular intervals. The recorded quantity of one CD item checked at random was the same as the physical amount of stock available. The right RP notice was clearly displayed, and the RP record was completed correctly.

Confidential waste was removed by a specialist waste contractor. Computers were password protected and the people using the pharmacy could not see information on the computer screens. Smartcards used to access the NHS spine were stored securely and team members used their own smartcards during the inspection. Bagged items waiting collection could not be viewed by people using the pharmacy.

The complaints procedure was available for team members to follow if needed and details about it were available in the pharmacy leaflet and displayed at the medicines counter. The pharmacist was not aware of any recent complaints.

The pharmacist had completed the Centre for Pharmacy Postgraduate Education training about protecting vulnerable people. Other team members had undertaken safeguarding training provided by the pharmacy's head office. Team members could describe potential signs that might indicate a safeguarding concern and would refer any concerns to the pharmacist. Team members said that there had not been any safeguarding concerns at the pharmacy. And the pharmacy had contact details available for agencies who dealt with safeguarding vulnerable people.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough team members to provide its services safely. They do the right training for their roles. And they are provided with some ongoing training to support their learning needs and maintain their knowledge and skills. Team members can take professional decisions and they can raise any concerns or make suggestions.

Inspector's evidence

There were two pharmacists, two trainee dispensers, one trained medicines counter assistant (MCA) who was also the pharmacy manager, and one trainee MCA working during the inspection. Some team members had completed an accredited course for their role and the rest were undertaking training or still within their probationary period. Team members wore smart uniforms with name badges displaying their role. The second pharmacist was undertaking New Medicine Service (NMS) follow up calls during the inspection but could help in the dispensary if needed. Team members said that a second pharmacist worked one day a week to ensure that the NMS service was managed safely. The second pharmacist explained that the NMS as provided for the benefit of the patients and not to meet targets. The team worked well together and communicated effectively to ensure that tasks were prioritised, and the pharmacy remained up to date with its dispensing.

The trainee MCA appeared confident when speaking with people. She knew which over-the-counter medicines could be misused or may require additional care. And she said that she would refer to the pharmacist if a person regularly requested to purchase these medicines. She knew which questions to ask to establish whether a medicine was suitable for the person it was intended for. And she was aware of the restrictions on sales of medicines containing pseudoephedrine.

The pharmacists felt able to make professional decisions and were aware of the continuing professional development requirement for professional revalidation. The RP said that he had completed declarations of competence and consultation skills for the services offered, as well as associated training. And he had recently undertaken training about the flu vaccination service. The pharmacy manager said that team members were provided with training on a regular basis. And they could complete this at work during quieter periods or at home.

The pharmacy held informal huddles each morning to discuss any issues and allocate tasks. The pharmacy manager said that team members had ongoing informal appraisals and performance reviews. She said that there had not been any formal ones carried out for a few years. But this was due to be reinstated soon. Targets were not set for team members.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises provide a safe, secure, and clean environment for the pharmacy's services. People can have a conversation with a team member in a private area.

Inspector's evidence

The pharmacy was secured from unauthorised access. It was bright, clean, and tidy throughout which presented a professional image. Pharmacy-only medicines were kept behind the counter and there was a clear view of the medicines counter from the dispensary. This meant that the pharmacist could hear conversations at the counter and could intervene when needed. Air conditioning was available, and the room temperature was suitable for storing medicines.

There were two chairs in the shop area. These were positioned away from the medicines counter to help minimise the risk of conversations at the counter being heard. Toilet facilities were clean and not used for storing pharmacy items. And there were separate hand washing facilities available. The staff kitchen area was kept clean and tidy.

The consultation room was to the rear of the dispensary, and it was accessible to wheelchair users. It was suitably equipped and well-screened. Conversations at a normal level of volume in the consultation room could not be heard from the shop area. Access to the room was through the dispensary. The pharmacist said that people using the consultation room would not be left on their own. And people’s personal information on dispensed items was not visible.

Principle 4 - Services ✔ Standards met

Summary findings

Overall, the pharmacy provides its services safely and manages them well. People with a range of needs can access the pharmacy's services. And people who get their medicines in multi-compartment compliance packs generally receive the information they need to take their medicines safely. 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

Team members had a clear view of the main entrance from the medicines counter and could help people into the premises where needed. And there was step-free access to the pharmacy through a wide entrance. Services and opening times were clearly advertised and a variety of health information leaflets was available. And the pharmacy could produce large-print labels for people who needed them.

Prescriptions for higher-risk medicines were highlighted, so there was the opportunity to speak with these people when they collected their medicines. The pharmacist said that he asked people about their recent blood test results where appropriate and would record these on the person's medication record. Prescriptions for Schedule 3 CDs were highlighted but those for Schedule 4 CDs weren't. This could increase the chance of these medicines being supplied when the prescription was no longer valid. The pharmacy manager said that she would ensure that these were highlighted in future. Dispensed fridge items were kept in clear plastic bags to aid identification and storage instructions were printed on the bags. The pharmacy manager said that fridge items were checked with people when handing them out. A team member said that the pharmacy supplied valproate medicines to a few people. But there were currently no people in the at-risk group who needed to be on the Pregnancy Prevention Programme (PPP). The pharmacist said that he would refer a person to their GP if they were not on a PPP and needed to be on one.

The pharmacy used licensed wholesalers to obtain medicines and medical devices. Drug alerts and recalls were received from the pharmacy's head office. The pharmacist explained the action the pharmacy took in response to any alerts or recalls. Any action taken was recorded and kept for future reference and this made it easier for the pharmacy to show what it had done in response. Stock was stored in an organised manner in the dispensary. Expiry dates were checked every three months and this activity was recorded. Items due to expire within the next six months were marked. There were no date-expired items found in with dispensing stock and medicines were kept in their original packaging. Denaturing kits were available for the safe destruction of CDs. CDs were stored in accordance with legal requirements, and they were kept secure. CDs that people had returned, and expired CDs were clearly marked and segregated. Returned CDs were recorded in a register and destroyed with a witness, and two signatures were recorded. Fridge temperatures were checked daily with maximum and minimum temperatures were recorded. Records indicated that the temperatures were consistently within the recommended range. The fridge was suitable for storing medicines and was not overstocked.

Part-dispensed prescriptions were checked daily. 'Owings' notes were provided when prescriptions could not be dispensed in full, and people were kept informed about supply issues. Prescriptions for

alternate medicines were requested from prescribers where needed. A tracker was used, and team members updated this with the latest action they had taken to try and obtain the medicines. Prescriptions were kept at the pharmacy until the remainder was dispensed and collected. Uncollected prescriptions were checked monthly. The pharmacy manager said that people were routinely contacted to ask if they still required their medicines. Uncollected prescriptions were returned to the NHS electronic system or to the prescriber and the items were returned to dispensing stock where possible.

The pharmacist said that people had assessments carried out to show that they needed their medicines in multi-compartment compliance packs. The pharmacy did not order prescriptions on behalf of people who received their medicines in these packs. A team member explained that she would contact a surgery if the pharmacy had not received the prescriptions for a person before their packs were due. The pharmacy kept a record for each person which included any changes to their medication, and they also kept any hospital discharge letters for future reference. Packs were suitably labelled and there was an audit trail to show who had dispensed and checked each pack. Medication descriptions were put on the packs to help people and their carers identify the medicines. But the patient information leaflets were not routinely supplied. A team member said that she would ensure that these were supplied in future.

Prescription deliveries were made by a delivery driver. The pharmacy obtained people's signatures for deliveries where possible. There were multiple people's details on each signature sheet so the layout might make it harder to ensure that people's details were protected when signatures were recorded. The pharmacy manager said that she would ensure that other people's personal information was protected when signatures were recorded in future. When the person was not at home, the delivery was returned to the pharmacy before the end of the working day. A card was left at the address asking the person to contact the pharmacy to rearrange delivery. A copy of the delivery list was kept at the pharmacy for reference.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide its services safely. It uses its equipment to help protect people’s personal information.

Inspector's evidence

Suitable equipment for measuring liquids was available. Separate liquid measures were used to measure marked for certain medicines only. Triangle tablet counters were available and clean. A separate counter was marked for cytotoxic use only. This helped avoid any cross-contamination. Tweezers were available so that team members did not have to touch the medicines when handling loose tablets or capsules.

Up-to-date reference sources were available in the pharmacy and online. The blood pressure monitor was replaced in line with the manufacturer’s guidance. The weighing scales and the shredder were in good working order. The phone in the dispensary was portable so it could be taken to a more private area where needed.

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.