General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: St. Marks Pharmacy, 80 Tennyson Road, St Marks, CHELTENHAM, Gloucestershire, GL51 7DB

Pharmacy reference: 1031513

Type of pharmacy: Community

Date of inspection: 23/09/2020

Pharmacy context

This is a community pharmacy in the northern outskirts of the town of Cheltenham. A wide variety of people use the pharmacy, but most people are elderly. The pharmacy team members dispense prescriptions, sell over-the-counter medicines and give advice. They supply several medicines in multi-compartment compliance packs to help vulnerable people in their own homes to take their medicines. The pharmacy also supplies medicines in compliance packs for the residents of several care homes. The pharmacy offers several services including Medicines Use Reviews (MURs), the New Medicine Service (NMS), the Community Pharmacy Consultation Service (CPCS) and seasonal flu vaccinations. The inspection was carried out during the COVID-19 pandemic.

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	4.1	Good practice	The pharmacy offers a good range of services and everyone can access the services it offers. It has good procedures to safely deliver the 2020 flu vaccine.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance ✔ Standards met

Summary findings

The pharmacy's working practices are safe and effective. It has made changes to its written procedures as a result of COVID-19. And, physical measures are in place to reduce the risk of transmission of coronavirus. The pharmacy is appropriately insured to protect people if things go wrong. It mainly keeps the required records. The pharmacy team members keep people's private information safe and they know how to protect vulnerable people. But they could be better at learning from mistakes to prevent them from happening again.

Inspector's evidence

The pharmacy team members identified and managed the risks associated with providing its services. They had put several physical changes in place, as a result of the COVID-19 pandemic, to reduce the risk of transmission of coronavirus (see under principle 5). The pharmacy had updated its standard operating procedures (SOPs) with changes relating to the pandemic. The pharmacy had also updated its business continuity plan to accommodate any potential issues relating to the current NHS 'test and trace' scheme. The pharmacy was part of a small group. The group would work together to ensure that there was no disruption in the supply of medicines to patients if any pharmacy in the group had to close. The manager had conducted risk assessments of the premises and occupational risk assessments of all the staff. The team members were asked about any potentially vulnerable people in their households and also about their mental health. The risk assessments were reviewed monthly. The pharmacy team members were aware that they needed to report any COVID-19 positive test results.

The pharmacy acted as a dispensing hub for the group. It assembled medicines into individual pouches for both domiciliary people and for the residents of care homes. This was done in a large separate building at the rear of the main pharmacy. The medicines were placed into the pouches by a robot. The hub dispensary was organised and tidy. The team members had a clear dispensing schedule. They used baskets with coloured labels to distinguish the different areas. An accuracy checking technician (ACT) or an accuracy checking dispenser (ACD) performed a physical check of all the pouches. The dispensary in the main pharmacy was limited in size. But there was a dedicated checking area. The dispensary team placed the prescriptions and their associated medicines into baskets. The pharmacist only had one basket at a time in the checking area. This reduced the risk of mistakes.

The team members recorded near miss mistakes, that is, mistakes that were detected before they had left the premises. Few learning points and actions to prevent future recurrences were documented. But the dispensary team members had placed alert stickers on the shelf-edges of common 'look alike, sound alike' (LASA) medicines. They reviewed the near miss log each month but no specific actions to reduce the risk of mistakes had been implemented.

All the staff were clear about their roles and responsibilities. A NVQ2 trained dispenser said that she would refer anyone on prescribed medicines who requested to buy a cough mixture to the pharmacist. All the pharmacy team members knew that codeine-containing medicines should only be sold for three days use. They referred anyone wanting to buy multiple packs of painkillers to the pharmacist.

The pharmacy team members knew about their complaints procedure. The pharmacy had not received

any complaints from people since the outbreak of the pandemic. The team members said that the people using the pharmacy were grateful for their hard work and dedication during this difficult time.

The pharmacy had current public liability and indemnity insurance provided by the National Pharmacy Association (NPA). It mainly kept the required up-to-date records: the responsible pharmacist (RP) log, controlled drug (CD) records, emergency supply records and specials records. It recorded private prescription electronically. Many of these did not have the required prescriber details. The pharmacy also had fridge temperature records, date checking records, patient-returned CD records and cleaning rotas.

All the staff understood the importance of keeping people's private information safe. They stored all confidential information securely. The computers, which were not visible to the customers, were password protected. The correct NHS smartcards were seen in the appropriate computers. The pharmacy team members shredded all confidential wastepaper. The pharmacy offered face-to-face services. These were done in the consultation room. People could not be overheard in the consultation room. They could however be seen by the pharmacy staff. The superintendent gave assurances that this would be addressed.

The pharmacy team understood safeguarding issues. The pharmacist had completed the Centre for Pharmacy Postgraduate Education (CPPE) module on safeguarding. The pharmacy had local telephone numbers to escalate any concerns relating to both children and adults. The pharmacist was aware of the national 'safe space' initiative for victims of domestic violence but the pharmacy was not signed up to provide this service.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough staff to manage their workload safely. The team members are flexible and cover holidays and sickness. The pharmacy team work well together and they are comfortable about raising concerns to their manager. She acts on these. The pharmacy team members are told about any updates and advice regarding COVID-19. But they could be doing more non-COVID learning to make sure that their general pharmacy skills and knowledge are up to date.

Inspector's evidence

The pharmacy's current staffing profile was: one pharmacist, one pre-registration student, two part-time accuracy checking technicians (ACTs) (not seen), one part-time accuracy checking dispenser (ACD), two full-time NVQ2 qualified dispensers, three part-time NVQ2 qualified dispensers and two part-time delivery drivers. The part-time staff were flexible and generally covered any unplanned absences. Planned leave was booked well in advance and only one member of staff could be off at one time. A staffing rota was used to ensure appropriate staffing levels with the desired skill mix.

The staff worked well together as a team. The manager monitored the performance of the team members. They had an annual appraisal where any learning needs could be identified. Review dates would be set to achieve this. The team members had monthly staff meetings. They all felt able to raise any issues or concerns with the manager and that these would be acted on. They had raised concerns at the beginning of the pandemic about their supplies of personal protective equipment (PPE). Because of this, the manager actively ensured that the pharmacy had sufficient supplies of PPE. The team members also said that they were supported with any mental health issues relating to the pandemic.

Since the outbreak of the pandemic, most of the pharmacy team members' learning was related to updates regarding coronavirus. They were not currently doing any on-going non-COVID learning. All the team members reported that they were supported to learn from errors. The GPhC registrants documented all learning on their continuing professional development (CPD) records.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy looks professional and is suitable for the services it offers. It is clean, tidy and organised. The premises are thoroughly cleaned to reduce the likelihood of transmission of coronavirus. The pharmacy signposts its consultation room well so it is clear to people that there is somewhere private for them to talk.

Inspector's evidence

The premises presented a professional image. The hub dispensary was spacious, organised and tidy. This was where the pouched medicines were assembled. The dispensary in the main pharmacy was limited in size but the pharmacist was aware of the risk that this posed. She only had one basket in the checking area at a time to mitigate this risk. To the back of the dispensary, in the main pharmacy, there was a separate area where the staff assembled medicines into conventional multi-compartment compliance packs. The floors in all the dispensing areas were clear. The premises were clean. As a result of COVID, the premises was thoroughly cleaned every day. The hard surfaces were wiped over more frequently than this. A deep clean of the premises was done on Saturday. The manager had updated the cleaning rota to reflect these changes. All the team used alcohol gel or washed their hands after each interaction with people.

The consultation room was well signposted. People could not be overheard in the consultation room. The pharmacy's computer screens were not visible to customers. The telephone was cordless and the staff took all sensitive calls out of earshot. The temperature in the pharmacy was below 25 degrees Celsius and it was well lit.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy offers a good range of services and everyone can access the services it offers. It has good procedures to safely deliver the 2020 flu vaccine. The pharmacy generally manages its other services effectively to make sure that they are delivered safely. The pharmacy gets its medicines from appropriate sources and stores them safely. It makes sure that people only get medicines or devices that are safe. But the team members could be better at telling the pharmacist about anyone who may need to be counselled by her, so that they fully understand their medicines.

Inspector's evidence

Everyone could access the pharmacy and the consultation room. The pharmacy team members could access an electronic translation application for any non-English speakers. The team members could print large labels for sight-impaired people.

The pharmacy was located in the northern outskirts of the town of Cheltenham. Most of its prescriptions were electronically transferred from local surgeries and many were for local residents. But the pharmacy acted as a dispensing hub for other branches. These prescriptions were scanned from the branches using a safe application connected to NHS email. The pharmacist at the branches was responsible for the clinical check of prescriptions and there was an adult trail demonstrating that this had been done. The medicines for the branch pharmacies were assembled by a robot into individual pouches. The stock for this process was checked but there was no audit trail demonstrating this. All the pouches received a full accuracy check by an ACT or ACD. There was a clear audit trail of this. The dispensary staff in the main dispensary initialled the 'dispensed by' and 'checked by' boxes on the labels, so providing a clear audit trail of their dispensing process.

In addition to the essential NHS services, the pharmacy offered several additional services: Medicines Use Reviews (MURs), the New Medicine Service (NMS), the NHS emergency hormonal contraception (EHC) service, the Community Pharmacy Consultation Service (CPCS), the Gloucestershire Urgent Repeat Medicine Service (URMS), supervised consumption of methadone and buprenorphine, a needle exchange service and the seasonal flu vaccination service (NHS and private).

The pharmacist had started providing the 2020 flu vaccinations. The NHS in the south-west had funded a new electronic means of pre-populating the pre-assessment form for the vaccinations, PreConsult. The application allowed the form to be pre-populated. It could be used in two different ways. People could scan a QR code (a two-dimensional version of a barcode made up of black and white pixel patterns), on their own smartphone and enter their own information. Or, the pharmacy team members could enter the patient information, in the pharmacy or during a telephone booking. By reducing the pharmacist/person contact time, PreConsult helped to reduce the infection risk and to increase the capacity of the pharmacy to deliver a larger number of vaccinations. The pharmacist wore a type 2 fluid-resistant mask. She used alcohol gel or washed her hands before and after each vaccination. Everyone who received the vaccine wore a face covering. The consultation room was thoroughly cleaned after the vaccination. 90% of the vaccinations were done following a previously arranged appointment.

The pharmacy had several substance misuse clients who usually had their medicines supervised. Due to COVID-19, most of these clients now collected their medicines. A few were still supervised. The

medicines were assembled using a Methameasure machine. This took place in the consultation room. The client disposed of the container themselves into a dedicated bin. The supervising pharmacist washed their hands after the supervision.

A large proportion of the pharmacy's business was the supply of medicines in pouches for the other branches in the group and the supply of medicines in pouches for the residents of several care homes. The pharmacy had an organised dispensing schedule for these prescriptions and all the branches had a copy of this. The dispensary team members kept communication diaries for all the care homes where they recorded any issues. They ordered repeat prescriptions from the residents' repeat prescription slips. The pharmacy did not send the prescriptions to the homes for checking prior to the medicines being assembled into the pouches. The team were informed of any changes of medication by the care home staff. The person's doctor did not send written confirmation of any changes to the pharmacy. The superintendent said that he would arrange meetings with all the surgeries to discuss this issue.

The pharmacy had several domiciliary people of their own who had their medicines supplied in more conventional compliance packs. The staff kept dedicated folders for these people where they recorded any changes in dose or other issues. The pharmacist referred to these when doing the final accuracy check. The dispensary team assembled the compliance packs in a small area to the back of the dispensary in the main pharmacy. The assembled packs were stored tidily.

The dispensary team did not routinely highlight prescriptions containing potential drug interactions, changes in dose or new drugs to the pharmacist. This meant that she may not realise that some people should be counselled about their medicines. The pharmacist did routinely counsel people prescribed high-risk drugs such as warfarin and lithium and also those prescribed antibiotics, loop diuretics or complex doses. All the pharmacy team members were aware of the pregnancy protection programme regarding sodium valproate.

The pharmacy delivered several medicines to people and to care homes. Because of the pandemic, the delivery drivers did not currently ask people to sign for their medicines to indicate that they had received them safely. They knocked or rang the doorbell and left the medicines on the doorstep. The drivers retreated and waited until the medicines had been taken safely inside. The drivers annotated the delivery sheets accordingly. They recorded the name of the person who accepted the medicines on behalf of the residents of the care homes.

The pharmacy got its medicines from Alliance Healthcare, AAH and Day Lewis Supply Partners. The pharmacy had two scanners to check for falsified medicines as required by the Falsified Medicines Directive (FMD) but they were not being used. It stored its CDs tidily in accordance with the regulations and access to the cabinet was appropriate. The pharmacy had some out-of-date and patient-returned CDs. These were clearly labelled and separated from usable stock. Appropriate CD destruction kits were on the premises. The pharmacy stored its fridge lines correctly and it had date checking procedures. The pharmacy team members were accepting patient-returned medicines. These were double bagged. The staff member who accepted the returned medicines wore gloves and washed their hands after disposing of the medicines into a dedicated waste bag. The team members placed any medicines, considered hazardous for waste purposes, into a separate dedicated waste bin.

The pharmacy had procedures for dealing with concerns about medicines and medical devices. The pharmacy received drug alerts electronically. They were printed off and the stock was checked. The pharmacy had received an alert on 7 September 2020 about amlodipine 10mg tablets. It had none of the affected batches in stock and this was recorded.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the appropriate equipment and facilities for the services it provides. And, the team members make sure that they are clean and fit-for-purpose. The pharmacy has taken action to reduce the spread of coronavirus with the use of protective screens and equipment.

Inspector's evidence

As a result of the pandemic, the pharmacy only allowed one person at a time to come in. The front retail area was relatively small. The pharmacy team members had erected a robust Perspex screen. This covered the entire medicine counter. They had also erected a protective screen in the consultation room. A hole had been cut out of this. People having a flu vaccination could place their arm through the hole. And the substance misuse clients could receive their medicines through this hole. All the staff were wearing Type 2R fluid resistant face masks.

The pharmacy used British Standard crown-stamped conical and ISO stamped straight measures. There were tablet-counting triangles, one of which was kept specifically for cytotoxic substances. These were cleaned with each use. The dispensing robot was subject to a 24-hour call out. The pharmacy had contingency measures in place if any issue could not be resolved in this timescale. It had up-to-date reference books, including the British National Formulary (BNF) 78 and the 2019/2020 Children's BNF. The staff could access to the internet.

The fridge was in good working order and maximum and minimum temperatures were recorded daily. The pharmacy computers were password protected and not visible to the public. There was a cordless telephone and the staff took any sensitive calls out of earshot. The pharmacy team members shredded all confidential waste information.

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.