General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: The Painswick Pharmacy Ltd, New Street, Painswick, STROUD, Gloucestershire, GL6 6XH

Pharmacy reference: 1031594

Type of pharmacy: Community

Date of inspection: 27/08/2024

Pharmacy context

This is a community pharmacy in the small Cotswold town of Painswick, near Stroud, Gloucestershire. The pharmacy dispenses NHS and private prescriptions. It offers local deliveries, the New Medicine Service (NMS) and Pharmacy First. The pharmacy also provides people's medicines inside multi-compartment compliance packs if they find it difficult to take them. This includes people in their own homes and residential care homes.

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	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 identifies and manages the risks associated with its services in a satisfactory way. Members of the pharmacy team deal with their mistakes responsibly. But they are not always documenting and formally reviewing the necessary details. This could mean that they may be missing opportunities to spot patterns and prevent similar mistakes happening in future. The pharmacy protects people's private information appropriately. Team members understand their role in protecting the welfare of vulnerable people. And the pharmacy largely keeps the records it needs to by law.

Inspector's evidence

At the point of inspection, most of the pharmacy staff were not present but the team knew which activities could take place in the absence of the responsible pharmacist (RP). Staff were clear on their roles and responsibility, and members of the pharmacy team knew what their tasks involved. The pharmacy had standard operating procedures (SOPs) to provide its team with guidance on how to complete tasks appropriately. Staff had read and signed the SOPs, including updates and addendums. The correct notice to identify the pharmacist responsible for the pharmacy's activities was on display.

Staff explained that to help maintain safety in the dispensary, team members did not rush, they worked at a set pace and double-checked relevant details to help avoid mistakes. Prescriptions were prepared in one area of the dispensary, and pharmacists checked medicines for accuracy from another section. One dispenser usually processed prescriptions through the pharmacy's system, and another assembled them. This meant that more than one accuracy check took place before prescriptions reached the RP for the final accuracy check. Expiry dates on packs of medicines were checked during the accuracy checking process and staff ensured the dates on prescriptions for CDs were within the 28-day expiry. There was also some evidence that look-alike and sound-alike medicines had been identified and highlighted.

However, the dispensary and parts of the pharmacy were quite cluttered in places. The inspector was told that the pharmacy was usually kept cleaner and tidier when all the pharmacy's team members were present. Staff were also not routinely recording errors that occurred during the dispensing process (near miss mistakes). The last details seen recorded were from 2023 and only one recorded in 2024. Staff said that they were informed about their mistakes, but the details were not being regularly or formally identified, collated, or reviewed. This could make it harder to identify any patterns or trends.

The RP described handling dispensing incidents which reached people and complaints in a suitable way and the relevant details were investigated appropriately. However, they were recorded on individual people's medication records. This information was not directly accessible unless the name of the person involved was known. This could also make it harder to spot patterns and trends.

The RP had been trained to level three to safeguard the welfare of vulnerable people. Members of the team could also recognise signs of concern; they had been trained to level one and the pharmacy had an appropriate policy in place along with contact details for the local safeguarding agencies. In addition, details about 'Ask for ANI' were on display in the dispensary to help guide staff. The pharmacy had an information governance policy and team members were trained to protect people's confidential information. They had also signed confidentiality clauses. The pharmacy stored confidential information

securely and separated confidential waste which was collected by an authorised carrier for destruction.

The pharmacy had current professional indemnity insurance. A sample of registers seen for controlled drugs (CDs) had been maintained in accordance with legal requirements. On randomly selecting CDs held in the cabinet, their quantities matched the stock balances recorded in the corresponding registers. Records of CDs that had been returned by people and destroyed at the pharmacy had also been maintained. The RP record was complete along with records to verify that the temperature of the fridge had remained within the required range. Within the electronic register for supplies made against private prescriptions, however, details of the prescribers were inaccurate which could make it harder for the pharmacy to find these details in the event of a future query. And the nature of the emergency when a supply of a prescription-only medicine was made, in an emergency without a prescription had not been recorded. This could make it harder for the pharmacy to justify the supplies made. These points were discussed with the superintendent pharmacist (SI) at the time.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy provides its services using a team with various levels of experience. It supports its team members in their roles. And gives them access to training resources to complete their ongoing training. This helps keep their skills and knowledge up to date.

Inspector's evidence

During the inspection, the pharmacy team consisted of the superintendent pharmacist who was also the regular RP, and a trainee dispensing assistant. The latter was enrolled onto appropriate accredited training in line with her role and was ready to sit the exam for this qualification. The delivery driver was also seen. The team was up to date with the workload, people were observed to be served promptly and efficiently and the team confirmed that the pharmacy usually had enough staff to support the workload. Some team members worked during school term-time only, or were part-time, one member of staff had left the pharmacy's employment and had not been replaced. The inspector was told that the team struggled to manage during school holidays or planned leave and the pharmacy found it difficult to arrange contingency cover. But the situation was said to be still manageable.

Team members asked appropriate questions and counselled people before they recommended or sold over-the-counter (OTC) medicines. Staff were aware of the maximum quantities of medicines that could be sold OTC or medicines that could be abused. They also knew when to refer to the pharmacist appropriately. Staff said that they loved working at the pharmacy due to the service they provided to people who used their services, they liked working with medicines and because they were given opportunities to progress. The trainee dispenser was a long-standing member of the team, she was provided with time to complete her training at the pharmacy. As they were a small team, meetings and discussions were said to take place regularly. Staff performance was managed as an informal process and the team could easily raise concerns and provide feedback. Team members took instruction from the RP and were provided with other resources for ongoing training through organisations which provided support for pharmacies.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy’s premises provide an environment which is appropriate for people to receive its services. And they are sufficiently clean and secure.

Inspector's evidence

The pharmacy’s premises consisted of an appropriately sized and suitably presented retail area with limited space in the dispensary. More storage and staff areas were present to one side and one area of the retail area had been cordoned off to allow the pharmacist to work in this area. But the latter and some of these areas were quite cluttered. They were not visible to or accessible by members of the public. The dispensary had an adequate amount of space for staff to carry out dispensing tasks safely in line with the pharmacy’s volume of dispensing. The lighting and ambient temperature within the pharmacy was appropriate for storing medicines and safe working. The premises were also secure from unauthorised access. There was a relatively clean sink in the dispensary for preparing medicines and the pharmacy had hot and cold running water. The pharmacy also had a separate consultation room which was used to hold private conversations and provide services. The room was small but suitable for its purpose and there was a sign in the retail space to advise people that a consultation room was available.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy largely provides its services safely. The pharmacy sources its medicines from reputable suppliers and stores its medicines suitably. But the pharmacy does not always manage its medicines in the most effective way. The pharmacy has some checks in place to ensure that medicines are not supplied beyond their expiry date. But some of its records are missing. And the pharmacy's team members are not making many checks to help people with higher-risk medicines take their medicines safely.

Inspector's evidence

The pharmacy was open from 9am to 6pm Monday to Friday, and from 9am to 12pm on Saturdays and closed for lunch in the week between 1pm to 2pm. Details about some of the services offered as well as the pharmacy's opening times were clearly advertised, and the pharmacy had several posters on display to provide information about various health matters. There was also a noticeboard which provided details about prominent local information and two seats for people who wanted to wait for their prescriptions. People could enter the pharmacy through the front door, although this had a step. Staff explained that they served people at the door, there was previously a doorbell to alert them to this situation and that people in wheelchairs or with restricted mobility called the pharmacy beforehand. Some team members were multilingual which assisted people whose first language was not English. Staff also physically assisted people and used the consultation room when needed. Team members were aware of the local health facilities to signpost people accordingly if this was required. They also had access to comprehensive, documented information to assist with this.

The team used baskets to hold prescriptions and medicines during the dispensing process. This helped prevent any inadvertent transfer and the baskets were colour coded to help identify priority and different workstreams. Once staff generated the dispensing labels, there was a facility on them to help identify who had been involved in the dispensing process. Team members routinely used these as an audit trail.

The pharmacy only provided a few additional services. The service specification and Patient Group Directions (PGDs) to authorise the Pharmacy First service were readily accessible and had been signed by the RP. There was also guidance and checklists available for the staff on this service and suitable equipment was present as noted under Principle 5. The RP had been trained on how to use them.

People's medicines were delivered to them, and the team kept specific records about this service. This helped verify and trace who had received their medicines in this way. CDs and fridge lines were highlighted. Failed deliveries were mostly brought back to the pharmacy and notes were left to inform people about the attempt made. Medicines were however, left unattended if this was required. The driver and staff were aware of the risks associated with this, CDs and temperature-sensitive medicines were not left but appropriate records to help justify this practice had not been maintained.

Staff were aware of the additional guidance when supplying sodium valproate and the associated Pregnancy Prevention Programme (PPP). The pharmacy had identified people at risk, who had been supplied this medicine and educational material was available to provide upon supply of this medicine. Team members explained that prescriptions for people which required counselling were highlighted but

people prescribed other higher-risk medicines or medicines that required ongoing monitoring were not routinely identified. The team did not ask relevant questions or details about their treatment nor was this information regularly recorded. This was discussed with the SI following the inspection.

The pharmacy provided people who lived in their own homes and some residents in the care homes with their medicines inside compliance packs. This was in conjunction with the person's GP and once a need for this had been identified. Staff maintained records for people who received their medicines in this way. Queries were checked with the prescriber and the records were updated accordingly. All medicines were removed from their packaging before being placed inside the compliance packs. However, descriptions of the medicines inside the packs were not always provided and patient information leaflets (PILs) were not routinely supplied. This could make it harder for people to have up-to-date information about how to take their medicines safely. A few compliance packs had also been left unsealed overnight at the point of inspection. The risks associated with this practice had been minimised from the way that they were stored but these points were discussed at the time.

Some of the residents in the care homes received compliance packs, others required their medicines as original packs. The care homes ordered prescriptions for their residents and the pharmacy was provided with details of the requests. The team could therefore check for any discrepancies or errors and retained suitable audit trails. The pharmacy provided medication administration records (MARs) which had details about allergies as well as sensitivities included. The care homes were provided with details about drug alerts. Staff had not been approached to provide advice regarding covert administration of medicines to care home residents.

The pharmacy used licensed wholesalers to obtain medicines and medical devices. Medicines stored in the dispensary could have been stored in a more organised way. The team checked medicines for expiry regularly but there were no current records to verify when this had taken place. Short-dated medicines were identified and on randomly selecting some of the pharmacy's stock, there were no medicines seen which were past their expiry date. CDs were stored securely and the keys to the cabinet were maintained in a way which prevented unauthorised access. Medicines requiring refrigeration were stored in a suitable way. The latter included storing insulin inside clear bags which helped easily identify the contents on hand-out. Medicines which were returned to the pharmacy by people for disposal, were accepted by staff, and stored within designated containers. This included sharps or needles provided they were within sealed bins. Drug alerts were received electronically via email. Staff explained the action the pharmacy took in response and relevant records were kept verifying this.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs to provide its services safely. The pharmacy’s equipment is kept clean.

Inspector's evidence

The pharmacy's equipment included current and online access for reference sources, an appropriately operating pharmacy fridge, a legally compliant CD cabinet, triangle tablet and capsule counters. A blood pressure monitor, otoscope, tongue depressors, torch and thermometer were also available for the Pharmacy First Service. The pharmacy’s equipment was clean. Computer terminals were password protected and their screens faced away from people using the pharmacy. This helped prevent unauthorised access. The pharmacy also had portable telephones which meant that conversations could take place in private if required.

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.