General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Cross Chemist, 8 Redhill Road, Westmill Estate, HITCHIN, Hertfordshire, SG5 2NQ

Pharmacy reference: 1032222

Type of pharmacy: Community

Date of inspection: 08/10/2024

Pharmacy context

This community pharmacy is located in a largely residential area, providing its services mainly to people who leave nearby. Most of its activity is dispensing NHS prescriptions and providing other NHS services including seasonal flu and Covid-19 booster vaccinations, the hypertension case-finding service, substance misuse supplies and the Pharmacy First service. It delivers medicines to some people's homes and supplies medicines in multi-compartment compliance packs to some people. It also offers other private services under patient group directions (PGDs) including travel vaccinations.

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

The pharmacy generally identifies and manages risks effectively so that people receive safe services. Its team members know what they can and can't do in the absence of a pharmacist. And they protect people's information well. The pharmacy uses mistakes as opportunities to learn and improve and it largely keeps the records it needs to by law.

Inspector's evidence

There were written standard operating procedures (SOPs) available for team members to refer to and which reflected the services provided by the pharmacy. Most of these had been introduced in 2022 and there was a training record kept showing team members had mostly read the SOPs relevant to their roles. The dispensary manager had not yet signed the record for all the relevant SOPs but was planning to go through the outstanding ones with the responsible pharmacist (RP) in the very near future.

The pharmacy had a process to record and review near misses (dispensing mistakes detected and corrected before reaching a person). Team members were informed of their own mistakes and were usually asked to correct their mistakes. The records included information about how a mistake might have happened and improvements to prevent a similar event happening again. These records were also discussed with the rest of the team to raise awareness about possible risks when dispensing. There was also a process to manage dispensing errors (dispensing mistakes which weren't corrected before being handed out). The dispensary manager explained that if there was doubt about a supply, the person was contacted and advised not to take until the medicine was rechecked by the pharmacy. Dispensing errors would be recorded and reported.

When asked, members of the team could describe their roles and what they could and couldn't do if there was no pharmacist present. They understood that certain over-the-counter medicines could be misused or overused and could correctly describe how they would deal with repeat requests for these types of medicines. Only the dispensary manager or pharmacist dispensed schedule 2 controlled drugs (CDs) to minimise the risk of mistakes happening. The pharmacy had a complaints procedure and team members asked could explain how complaints would be handled. The pharmacy's services were suitably insured.

The pharmacy displayed a Responsible Pharmacist (RP) notice where members of the public could see it. The RP notice on display at the time of the inspection showed the correct information about the RP on duty. The pharmacy's RP record was largely complete though the end of the RP's was not always recorded. There was an electronic CD register in use. Balance checks were completed regularly, and a record kept of this activity. There was evidence that discrepancies found during balance checks were investigated and corrected. A spot check of the physical stock of a sample of medicines agreed with the running balance recorded. Private prescriptions were recorded electronically. Some of the records looked at did not include the correct information about the prescriber. This could make the records less reliable in the event of a future query.

No confidential information was visible to people visiting the pharmacy. Confidential waste was disposed of by shredding. Team members had completed training about protecting people's sensitive

information. Prescriptions waiting collection were stored out of sight and reach of the public. Passwords to access electronic prescriptions using NHS smartcards were not shared and team members were seen using their own smartcards during the visit.

There were procedures relating to safeguarding which team members were aware of and the RP had completed the required safeguarding training for the services they provided. A dispenser described how concerns about vulnerable people had been acted on and escalated to other agencies including people's GPs where needed. Team members would involve the pharmacist when dealing with safeguarding concerns.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough staff to provide its services safely. And its team members have either completed or are enrolled on accredited training for the roles they undertake. Ongoing development of team members' skills is encouraged and supported. Team members can ask for help from more experienced members of staff or discuss concerns or other issues they may be having, in an open way.

Inspector's evidence

At the time of the inspection, the pharmacist on duty was the regular RP. The rest of the team comprised three full-time trained dispensers, one of whom was the dispensary manager, one trainee dispenser who had just started at the pharmacy, and a part-time delivery driver. A foundation pharmacist wasn't present. The team members had either completed or had been enrolled on an accredited training course for the roles they undertook. And two of the trained dispensers were completing an accuracy checker's course. One of the dispensers explained how they had been actively encouraged to develop their skills by undertaking training to provide the ear micro suction service and the accuracy checking dispenser course, and felt well supported in doing so. They could describe the checks they made before providing micro suction, obtaining consent from people, the records they kept about the service, who they referred queries to when needed, and the aftercare advice they gave to people.

The team appeared to be managing the workload during the inspection though there was quite a queue of people waiting for the flu and Covid-19 vaccination service at times as walk-ins were being accepted. Holiday cover was planned to ensure there was sufficient cover. The dispensary manager explained how they and the RP would undertake urgent prescription deliveries on days when there was no planned delivery service.

The team members were observed working closely together and had a good rapport with their customers. When asked, team members said they would be comfortable raising any issues or concerns with the RP or the dispensary manager. The RP said they felt able to exercise their professional judgement when providing services to people. They described occasions when requests for treatment under the Pharmacy First service had been refused as they fell outside the treatment criteria and people had been referred elsewhere for support.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy's premises are adequate for the services the pharmacy provides. The pharmacy has a consultation room where people can receive services or have a conversation with a member of the pharmacy team.

Inspector's evidence

The external appearance of the pharmacy was in an adequate state of repair though the inside of the front windows and entrance door frame had cobwebs and there was a coating of dust on some of the shelves which detracted somewhat from the image presented. The retail area and dispensary were clearly separated. There were no slip or trip hazards or other obstructions in the retail area and some seating was available for people waiting for services. Lighting and ambient temperatures throughout the premises were suitable for the activities undertaken.

Most parts of the pharmacy including the sink used for preparing medicines and dispensing benches were reasonably tidy except for a storage room upstairs which was rather cluttered. The dispensary manager and RP accepted this needed to be better organised. Staff had basic hygiene facilities available; there was a separate sink for handwashing.

There was a consultation room next to the pharmacy counter which was in fairly constant use throughout the visit for vaccinations. The room had storage for equipment and sundries, and seating for the pharmacist and patient. This was reasonably tidy and was large enough for the activities undertaken. There was also access to patient medication records in the consultation room. When the door was closed, conversations inside the room could not be overheard from the shop floor.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy generally provides its services safely and it tries to make its services accessible to people with differing needs. It gets its medicines from appropriate sources, and it manages them reasonably well, so they are safe to supply to people. But it sometimes keeps medicines with different expiry dates and from different batches in the same container which could make it harder for the pharmacy to be sure that all its medicines are fit for purpose.

Inspector's evidence

There was level access from the street into the pharmacy with a shallow slope up to the counter area and consultation room. The pharmacy's opening hours and information about some of the services it offered were displayed in the windows. There were also some health information leaflets for people to read and take away. The pharmacy had a prescription delivery service for those who couldn't come to the pharmacy in person and kept records about this service as an audit trail.

The team members were observed dispensing prescriptions in an organised way and responding to people coming into the pharmacy promptly. Dispensing labels were initialled at the dispensing and accuracy checking stages to provide a clear audit trail in the event of a future query. Warning stickers were applied to some prescriptions that required extra care or special storage arrangements, such as CDs and fridge lines. The dispensary manager described the extra checks the pharmacy made when supplying higher-risk medicines that needed ongoing monitoring such as methotrexate and warfarin. This included checking the person was being monitored appropriately. The pharmacy was aware of the updated guidance relating to the use of valproate-containing medicines by people who could become pregnant and generally only supplied these medicines in original packs with all the necessary safety information provided. One person, not in the at-risk group, received valproate-containing medicines in multi-compartment compliance packs. The need for risk assessments when supplying these medicines outside of their original packs was discussed with the dispenser.

The NHS flu and Covid-19 vaccination service had started recently. Some people had booked appointments in advance, but the pharmacy was also accepting walk-in requests for vaccinations. There was an opportunity to manage the queuing system more effectively, but people appeared happy to wait in most cases. Most of the RP's time during the visit was taken up by this activity but they found time in between consultations to check prescriptions for people.

The pharmacy offered the NHS Hypertension Case-finding service. The dispensary manager explained how the pharmacy tried to link this with other services to promote people's awareness. The pharmacy had referred a number of people to their GP after detecting raised blood pressure readings and this had resulted in some people being treated for hypertension.

Multi-compartment compliance packs were prepared in an organised way and the pharmacy had robust processes to make sure packs were prepared on time. Most people received four weeks of packs at a time. Unexpected changes and missing items were queried, and an audit trail kept about these interventions. Packs were covered promptly to prevent contamination or transfer between sections. Prepared packs had an audit trail showing who had checked each pack but were not always signed by

the dispenser. The dispenser explained they were usually the only person involved in assembling the packs. The labelling on the packs seen included a description of the contents so people could more easily identify their medicines. Patient information leaflets were generally only supplied when new medicines were prescribed. This could mean people don't receive updated information about their medicines.

The RP could refer to hard copies of the patient group directions (PGDs) for the Pharmacy First service and these had been signed to ensure supplies were made safely and legally. He had also completed the required training. On occasions, the pharmacy had received referrals to the service from other healthcare providers which did not meet the inclusion criteria and so were out of scope of the service. These had sometimes created additional work for the pharmacy and inconvenience for people looking for treatment.

Medicines were obtained from a range of licensed wholesalers, and they were generally stored in an orderly way on dispensary shelves, in the medicine fridges and in the CD cabinets. Date checks were completed regularly and recorded. No date-expired medicines were found when spot checked. However, some medicines were not in their original container and some packs contained mixed batches with different expiry dates. This could make it harder to identify date-expired medicines or medicines affected by product recalls. The RP agreed to review this process. Team members explained how they managed medicine shortages including contacting people's GPs to discuss possible alternative treatments if needed. This activity was taking a significant amount of time each week.

The pharmacy had a process to receive all patient safety alerts and medicines recalls so it could take the right action to protect people. There was an audit trail showing how the pharmacy had responded to previous alerts and recalls.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide its services effectively. It checks that its equipment is working correctly. However, it could keep some of its counting equipment cleaner to prevent cross-contamination.

Inspector's evidence

Computer screens containing patient information could not be viewed by members of the public. The pharmacy had cordless phones so phone conversations could be held out of earshot of the public if needed. The team had access to online reference sources to provide advice and undertake clinical checks based on current information. There was suitable equipment for disposing of medicine waste safely. Equipment required for providing Pharmacy First consultations, including an otoscope, was available. A dispenser could explain clearly how the device used for micro suction was maintained, including the cleaning routine, so it was safe to use. Liquid medicines were measured using calibrated glass measures and these were generally clean though were scaled in places. Some were marked for a specific purpose to avoid cross-contamination. There was a triangle for counting tablets; this had some residue on it which could potentially transfer to other tablets. There was ample secure storage for CDs and the two medicine fridges provided sufficient refrigerated storage for medicines. There was no ice build-up in the fridges. Records kept for the fridges showed these maintained appropriate temperatures for storing temperature-sensitive medicines.

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.