General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Maple Pharmacy - South Wigston, 64 Blaby Road, South Wigston, LEICESTER, Leicestershire, LE18 4SD

Pharmacy reference: 1034028

Type of pharmacy: Community

Date of inspection: 04/11/2021

Pharmacy context

This is a community pharmacy situated on a busy road in South Wigston. Most of its activity is dispensing NHS prescriptions and giving advice about medicines over the counter. The pharmacy supplies medicines in multi-compartment compliance packs to people who live in their own home. Other services that the pharmacy provides include NHS flu vaccinations and the substance misuse service. The pharmacy also delivers medicines to people's homes. The pharmacist is also a pharmacist independent prescriber. This inspection was undertaken during the Covid-19 pandemic.

Overall inspection outcome

Standards not all met

Required Action: Improvement Action Plan

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 not all met	1.1	Standard not met	The pharmacy cannot show that it manages all the risks linked to the prescribing service appropriately. Prescribing decisions are not adequately recorded.
		1.6	Standard not met	Record keeping for the prescribing service is inadequate. The pharmacist is not making clear records about his prescribing decisions. This means that there is insufficient evidence to support the decision should a query occur, and this information is not available to support future prescribing decisions.
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 not all met	4.2	Standard not met	The pharmacy cannot show that its prescribing service always protects people's health and well-being. It does not always take all reasonable steps to confirm that the information provided by people is reliable.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance **Standards not all met**

Summary findings

The pharmacy cannot show that it manages all the risks linked to the prescribing service appropriately. And prescribing decisions are not adequately recorded. Since the inspection the pharmacy has put a clinical governance framework in place. But it still needs to show that this framework is being implemented and supports safe prescribing. However, the pharmacy manages people's personal information safely. And its team members have defined roles and accountabilities. The pharmacy mainly has adequate procedures to learn from its mistakes. But it doesn't record the regular review of its mistakes so it could be missing opportunities to learn from them.

Inspector's evidence

The pharmacist had taken the standard operating procedures (SOPs) home to review them. Although this meant that the SOPs were not available to refer to the dispenser could explain her role. She had a good understanding of how to sell medicines safely. She was aware that prescriptions had a six-month validity from the date on the prescription apart from controlled drugs (CDs) which had a 28-day validity. Not all the CDs waiting collection were highlighted to remind the team that the prescription was valid for only 28 days. This could increase the chances of CDs being handed out beyond their 28-day validity. The pharmacist said he would make sure prescriptions were highlighted.

The pharmacy had a process for recording dispensing mistakes that were identified before reaching a person (near misses) and dispensing mistakes where they had reached the person (errors). Near misses were discussed with the member of staff at the time and were mainly recorded in a near miss log. The pharmacist regularly reviewed the near miss log, but he didn't make a record of the review. The pharmacist highlighted the separation of amitriptyline and amlodipine on the shelves as an outcome of a near miss.

The pharmacy maintained appropriate legal records to support the safe delivery of pharmacy services. These included the responsible pharmacist (RP log), and the controlled drug (CD) registers. Patient-returned CDs were recorded in accordance with requirements. Out-of-date CDs were separated. Dispensed CDs waiting collection were in date. CD running balance audits were mainly carried out regularly but there were occasions when they had been missed. The private prescription record did not always record all the information required.

The pharmacy had started providing flu vaccinations. The pharmacist had completed the required training and had an in-date signed patient group direction in place. Both he and the customer wore masks, but the pharmacist didn't wear gloves or a cover to his clothes to provide additional protection. He said that he would re-read the NHS guidance on flu vaccinations and review his processes accordingly.

The pharmacist was an independent prescriber. He was prescribing for people who were finding it difficult to access local health service. This included where people required a continuation of a medicine already prescribed such as an inhaler and a diagnosis of a new condition such as antibiotics for a skin infection. The medicines prescribed included medicines that could be abused, or misused, antibiotics and medicines requiring ongoing monitoring. The pharmacist said that he had obtained the appropriate information from the person before deciding whether or not to prescribe but this had not always

included looking at their Summary Care Record. This might have meant that he did not have all the information he needed to make an appropriate decision. He wrote the prescription and made the supply himself. He made a record of the supply in the private prescription book, but the records seen did not have clear judgements to explain the reasons he had decided to prescribe. A clear record would demonstrate that he had assessed the risks appropriately and could inform decisions about future supplies. It would also allow the pharmacist to explain his clinical decision if there was a future query. The pharmacist did contact the GP to make them aware of the supply; this was good practice and showed shared care. The pharmacist accepted that he had not read the GPhC guidance for pharmacist independent prescribers. He did not have a written prescribing guide to create a clinical governance framework for his prescribing decisions. The clinical governance framework could include evidence of his areas of competence.

The pharmacy had appropriate professional indemnity insurance which also covered the services provided. There was a complaint procedure in place. Computer terminals were positioned so that they couldn't be seen by people visiting the pharmacy. Access to the patient medication record was password protected. Confidential waste was disposed of securely. The pharmacist was aware of safeguarding requirements; there were local contact details available for escalating concerns appropriately.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy's team adequately manages the day-to-day workload within the pharmacy. The team member is supported in her development and can raise concerns if needed.

Inspector's evidence

During the inspection the pharmacy team adequately managed the day-to-day workload. There was one pharmacist and a trainee dispensing assistant. The assistant was on an appropriate dispenser training course and also had informal training from the pharmacist. Workload had increased in the pharmacy, so the pharmacist was looking to employ another member of staff. The pharmacist said that the increased workload was one reason why not all clinical governance was being completed as regularly as he would like. The assistant said that she felt supported in her training and could raise concerns or issues when required.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy keeps its premises safe, secure, and appropriately maintained. And it has made some changes to help keep staff and people using the pharmacy safe during the pandemic.

Inspector's evidence

The pharmacy had a new bright modern facia which presented a good image. The inside of the pharmacy had also been updated with new lights and new fixtures and fittings to reflect the new name and ownership. The dispensary was a suitable size for the services provided. There was adequate heating and lighting, and hot and cold running water was available.

The pharmacy had a push-pull door and steps from the street which made it more difficult for people with a disability or with a pushchair to access the pharmacy. The pharmacist said he had arranged for a new automatic door to be fitted in the next couple of months.

The pharmacy had processes in place to support safe working during the Covid-19 pandemic. Because the pharmacy was usually quiet, they didn't need to have a sign restricting the number of people coming into the pharmacy. Once inside, there was a one-way system, but it wasn't clearly signposted at the entrance which could cause some confusion. The counter had a small clear plastic screen at the pharmacy counter which provided some re-assurance to both the staff and the customers. There was hand sanitiser available. The pharmacy was cleaned daily.

The pharmacy team carried out regular Covid-19 lateral flow tests. The pharmacist said if there was a positive test this would be reported to NHS England and the guidance in place would be followed. The team wore masks. Unauthorised access to the pharmacy was prevented during working hours and when closed.

Principle 4 - Services **Standards not all met**

Summary findings

The pharmacy cannot show that its prescribing service always protects people's health and well-being. It does not always take all reasonable steps available to confirm that the information provided by people is reliable. For example, by looking at people's Summary Care Records. The pharmacy does not routinely highlight prescriptions for higher-risk medicines that are waiting collection. This could make it harder to provide the information people need to take these medicines safely. However, the pharmacy has changed the way it provides services during the Covid-19 pandemic to keep its staff and the people who use its services safe. The pharmacy gets its medicines and medical devices from reputable sources. It mainly stores them safely and it takes the right actions if medicines or devices are not safe to use to protect people's health and wellbeing.

Inspector's evidence

The pharmacist knew most of the people who came into the pharmacy during the inspection by name. He engaged with them in a supportive and positive way. The pharmacist understood the signposting process and used local knowledge to direct people to other local health services when needed. The pharmacist knew the advice about pregnancy prevention that should be given to people in the at-risk group who took sodium valproate. The pharmacist gave a range of advice to people about other healthcare matters. Examples he gave included advice about changes in dose or new medicines. He also gave advice to people taking higher-risk medicines such as warfarin, lithium, and methotrexate. But the pharmacy didn't highlight these prescriptions to help make sure that when people collected them, they could be given advice regularly. The pharmacist said he would consider highlighting these prescriptions.

The pharmacist was an independent prescriber and provided a service prescribing medicines to people who were unable to access other local prescribing services. The pharmacist carried out a face-to-face consultation in the pharmacy before prescribing where he felt appropriate. He obtained information from the person and the pharmacy's patient medication records system but did not always use other information sources such as their Summary Care Record. He made the person's normal prescriber aware of the medicine that he had supplied. He explained that he only prescribed where he felt competent and highlighted his practical experience in a GP surgery. Managed appropriately, this service could relieve pressure on local services and provide people with another way of accessing the healthcare they need. However, at the time of inspection the pharmacist was unable to show that he had the appropriate clinical governance framework in place to support the service.

The pharmacy used a dispensing audit trail which included use of 'dispensed by' and 'checked by boxes' on the medicine label. This helped identify who had completed each task. The pharmacy also used baskets during the dispensing process to keep medicines and prescriptions separated to reduce the risk of a mistake being made. There was a process to make sure that each person who received their medicines in a multi-compartment compliance pack got them in a timely manner. The charts seen were a little unclear with changes crossed through and not always dated. The pharmacist said he was aiming to re-write the charts to make them clearer. The compliance packs seen had the colour and shape of medicines recorded on the packs to make the medicines easily identifiable. Patient information leaflets were sent each time a person had the medicine. The pharmacist delivered medicines to some people. He maintained appropriate distance due to the pandemic.

The space for storing medicines in the dispensary was a little small. This meant that on the shelves, different strengths of medicines and sometimes different medicines were stored on top of each other. The pharmacist said that he was aware of the risks and was looking to increase the storage area for medicines. Most, but not all, bottles had the dates that they had been opened recorded. The pharmacist said he would make sure that going forward he would record all dates. Date checking was carried out regularly. A sample of medicines checked were in date. Records showed that medicines that needed to be refrigerated were stored within the required range of 2 and 8 degrees Celsius. The pharmacy only used recognised wholesalers to supply them with medicines. The pharmacy had a procedure for managing drug alerts appropriately.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has access to the appropriate equipment and facilities to provide the services it offers safely.

Inspector's evidence

The pharmacy used suitable measures for measuring liquids. The pharmacy had up-to-date reference sources. CDs were stored securely. Records showed that portable electrical equipment had not been recently safety tested. The pharmacy manager said he would look to arrange for testing. The equipment looked in a reasonable condition.

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.