General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Ask Chemist, 13 Forbes Road, BOSTON, Lincolnshire, PE21 0PD

Pharmacy reference: 1034237

Type of pharmacy: Community

Date of inspection: 10/01/2024

Pharmacy context

The pharmacy is on a residential estate in the market town of Boston, Lincolnshire. Its main services include dispensing NHS prescriptions and selling over-the-counter medicines. The pharmacy supplies some medicines in multi-compartment compliance packs, designed to help people remember to take their medicines. It also supplies medicines to people living in care homes. And it offers a medicine delivery service.

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 does not appropriately assess and address the risks associated with providing its services. It does not have written procedures designed to support the safe and effective running of the pharmacy available for its team members to refer to. And they do not always follow safe working practices.
		1.2	Standard not met	The pharmacy does not do enough to record and learn from mistakes. And team members cannot demonstrate adequate learning from these types of events.
2. Staff	Standards met	N/A	N/A	N/A
3. Premises	Standards not all met	3.1	Standard not met	The pharmacy is disorganised and untidy so there is not sufficient space for its team members to complete routine dispensing tasks safely. This increases the risk of an adverse event occurring, including a risk of team members tripping and falling.
4. Services, including medicines management	Standards not all met	4.3	Standard not met	The pharmacy does not store all of its medicines safely and securely. And it does not have effective monitoring processes to ensure it keeps all its medicines at the right temperature and in date.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

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

Summary findings

The pharmacy does not adequately identify and manage all the risks with providing its services. It does not make procedures designed to support the safe and effective running of the pharmacy available to its team members. And it does not help its team members in reporting and reflecting on mistakes they make during the dispensing process. This means they miss opportunities to learn from mistakes and prevent reoccurrence. Overall, pharmacy team members protect people's personal information. They know how to manage feedback and understand how to act to protect vulnerable people.

Inspector's evidence

The pharmacy transferred ownership in September 2023. Since this date workload had grown significantly following the closure of the current owner's other pharmacy. The pharmacy did not have standard operating procedures (SOPs), designed to support its safe and effective running available for team members to refer to. Pharmacy team members were aware of what tasks could and could not take place in the event the responsible pharmacist (RP) took absence from the pharmacy. Observations found several team members completing tasks without the necessary care and attention required. For example, handing out assembled bags of medicines to people without making checks to ensure they had selected the correct bag. And leaving assembled bags of medicines outside near a delivery van unattended. Team members were observed completing dispensing tasks in a cramped environment with very little space to move effectively around the dispensary.

The pharmacy team had recorded six incidents since September 2023 on its patient medication record (PMR) system. These records did not specify whether they were mistakes made and identified during the dispensing process, known as near misses. Or whether they were mistakes made and identified following the supply of a medicine to a person, known as dispensing incidents. There was limited information within the reports and there were no regular opportunities taken to share learning from mistakes to help reduce risk. Team members did not take the opportunity to record several near misses brought to their attention during the inspection. This heightened the chance that a similar mistake may occur.

Pharmacy team members knew how to manage feedback and concerns. They were committed to supporting people by answering queries and by providing dispensing services in a timely manner. And they knew to escalate concerns to the RP. The RP provided examples of how customer service had improved in the pharmacy in recent months and explained people left positive feedback about the service they received. Some team members had completed formal learning in previous roles about safeguarding vulnerable people. And there was some information available to team members to support them in reporting these types of concerns. A team member was observed taking time to discuss a vulnerable person's individual needs with them.

The pharmacy had current indemnity insurance. The RP notice on display contained the correct details of the RP on duty. And the RP record was generally completed in full; occasional records did not have the sign-out times of the RP. The pharmacy maintained running balances within its controlled drug (CD) register. But it had not completed a full balance check of CDs against the balance recorded in its register

for several months. And a physical balance check completed during the inspection did not match the balance recorded in the CD register. This was immediately investigated, and the cause found to be two missed entries. The pharmacy stored all information within the staff-only area of the premises and on password protected computers. It had appropriate arrangements to dispose of confidential waste securely.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough team members to manage its workload. It has some support systems to help members of the pharmacy team in learning roles. But it does not encourage its team members to regularly reflect on their practice and share learning to help support continual improvement. Pharmacy team members communicate well with each other. And they know how to raise a professional concern at work.

Inspector's evidence

On duty was the RP who was one of the pharmacy owners. They were supported by four dispensers, three trainee dispensers, two delivery drivers and a new member of the team who had worked in the pharmacy for several weeks. The pharmacy's superintendent pharmacist (SI) also worked at the pharmacy, and it employed another trainee dispenser. A regular locum pharmacist provided cover when needed. The pharmacy had recently employed a new delivery driver. And it was currently recruiting for another dispenser to join the team. Team members were able to keep up to date with dispensing tasks. But workflow was disorganised, and this increased the risk of a mistake occurring during the dispensing process.

One dispenser was enrolled on a pharmacy technician training programme. They were also completing an accredited checking dispensing assistant (ACDA) qualification. And another dispenser was also enrolled on the ACDA training course. Trainee team members explained they completed most of their learning in their own time due to the busy work environment. They were confident in seeking support with their learning from one of the pharmacists. And pharmacists monitored the progress of individual team members learning. The pharmacy used a number of delivery drivers. But not all drivers had completed accredited learning for their role in accordance with the GPhC's requirements for the education and training of pharmacy support staff. A discussion highlighted the need for the pharmacy to comply with the training requirements. And pharmacists acted immediately to enrol the drivers on a GPhC accredited training course. Team members were observed working well together and communicated effectively with each other to resolve queries about workload. They were aware of how to raise a concern at work but there was no whistleblowing policy available to support them in knowing how to escalate a concern in the event they needed to.

Principle 3 - Premises **Standards not all met**

Summary findings

The pharmacy premises are untidy, and the lack of space compromises the safety of the work environment. Cluttered workbenches increase the risk of team members making a dispensing mistake. The pharmacy is secure, and it maintains most physical fittings to an appropriate standard.

Inspector's evidence

The physical premises were secure and maintained to an adequate standard. There was some maintenance work ongoing as the new owners had looked at how they could increase space within the building. But other than two dedicated areas of protected space used to complete tasks for the supply of medicines in multi-compartment compliance packs there was very little free workspace in the dispensary. A team member was observed balancing a basket on a seat when completing tasks during the dispensing process. The RP's checking station was crowded as it was surrounded with stacked baskets of assembled medicines waiting to be checked. Work bench space in other areas of the dispensary was full of part-assembled bags of medicines waiting for stock, and stacked baskets and boxes with medicines and prescriptions inside. In addition to this floor space was compromised due to team members placing baskets containing prescriptions and labels on the dispensary floor and bulky stock further compromising space.

Off the dispensary was a small kitchen. Due to the lack of space in the dispensary this room was being used to hold some stock of medicines. A stock room at the back of the premises was used to hold further medicines. This room was cluttered but there was a clear walkway through the room to the fire exit. Lighting was bright and ventilation arrangements were appropriate. Team members had access to suitable hand washing facilities. The pharmacy's toilet facilities required cleaning and the cistern lid from the toilet was missing. The pharmacy's consultation room was temporarily unavailable as it was in the process of being refitted. A team member explained a pharmacist would speak to somebody by telephone if they required a quiet word whilst the work took place.

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

Summary findings

The pharmacy does not store all of its medicines safely and securely. And it does not make effective checks to ensure it stores and manages its medicines appropriately. The pharmacy obtains its medicines from reputable sources. It generally makes its services accessible to people and it provides appropriate information to people to help them take their medicines safely.

Inspector's evidence

People accessed the pharmacy from street level. The pharmacy advertised its opening hours. It was advertising a flu vaccination service but due to the temporary closure of the consultation room it did not have an appropriate space to vaccinate people. The RP stated the service had not been requested recently. The pharmacy protected Pharmacy (P) medicines from self-selection by displaying these behind the medicine counter. The RP was able to supervise the activity taking place in the public area from the dispensary. And they were observed intervening when their attention was required at the medicine counter.

The RP was observed providing counselling when handing out medicines to people. Team members spoken to were aware of the need for valproate to be dispensed in the manufacturer's original packaging. And they had knowledge of the checks required as part of the valproate pregnancy prevention programme. There was a range of tools available to support counselling when supplying higher-risk medicines to people. But these types of interventions were not recorded on the PMR to support continual care.

Pharmacy team members used baskets throughout the dispensing process to help keep all items for each prescription together. They took ownership of their work by signing their initials on dispensing labels to confirm their involvement in the dispensing process. The pharmacy retained prescriptions for the medicines it owed to people. But team members did not always provide people with a record of what was owed to them. This practice could make it more difficult for team members to manage queries about the medicines it owed. The pharmacy used a digital application to support it in delivering medicines to people. This software helped the team to plan effective delivery routes and provided real time updates about the status of a delivery should the team receive a query.

The pharmacy had schedules to support team members in managing tasks for the supply of medicines in multi-compartment compliance packs in a timely manner. The pharmacy used the PMR and individual profile sheets to record details of people's medicines. These records included details about changes made to medicine regimens. A sample of assembled compliance packs contained full dispensing audit trails, descriptions of the medicines inside them and a supply of patient information leaflets. The pharmacy supplied medicines in original manufacturer's packs for people residing in care homes. It supplied medicine administration records (MARs) when dispensing these medicines to assist care home teams in administering them.

The pharmacy sourced medicines from licensed wholesalers. It stored medicines in their original packaging. But storage throughout the dispensary was disorderly with different medicines mixed

together. This greatly increased the risk of a mistake occurring when team members picked medicines. The pharmacy stored its CD medicines in secure cabinets. But these cabinets were at capacity. There was a build-up of patient returned medicines identifiable within the cabinets waiting for destruction which limited the amount of free space for stock. The pharmacy's fridge was a suitable size for the medicines it held. But there were no recent records available to show the team was monitoring the operating temperature of the fridge. The minimum and maximum readings on the fridge thermometer remained within the required temperature range of two and eight degrees Celsius during the inspection.

Pharmacy team members explained they checked expiry dates of medicines during the dispensing process. But they did not take the opportunity to conduct full date checks of stock medicines on a rolling cycle. And a near miss picked up by the RP, involving a date expired medicine was brought to the attention of a team member during the inspection. A random check of stock across the dispensary found no out-of-date medicines. The pharmacy had medicine waste receptacles. But some yellow bags of medicine waste were observed on the floor in the multi-compartment compliance pack area, next to baskets of labelled prescriptions and some bulky stock items. The pharmacy had CD denaturing kits available for the secure destruction of CDs. The RP demonstrated how the team received safety alerts and recalls about medicines through email. And another team member discussed a very recent alert they had checked.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the necessary equipment to support the delivery of its services. And its team members use the equipment in a way which protects people’s privacy.

Inspector's evidence

Pharmacy team members had access to digital reference resources. They had internet access to support them in resolving queries or obtaining up-to-date information. And they used password-protected computers and NHS smartcards when accessing people's medication records. The pharmacy suitably protected information on computer monitors from unauthorised view. It stored bags of assembled medicine on designated shelving within the dispensary, and people's confidential information on bag labels could not be read from the public area. Pharmacy team members used appropriate counting and measuring equipment when dispensing medicines. Electrical equipment was in working order and cables and plugs were visibly free from wear and tear.

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.