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: 29/07/2024

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. It provides the NHS New Medicine Service (NMS), NHS blood pressure check service and NHS Pharmacy First service. The pharmacy supplies some medicines in multi-compartment compliance packs, designed to help people remember to take their medicines. 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	1.2	Standard not met	The pharmacy does not have appropriate monitoring arrangements to ensure its team members learn from their mistakes. And it does not act to reduce risk by safely storing medicines in an orderly manner.
		1.6	Standard not met	The pharmacy does not keep all its records in accordance with legal requirements. This includes records for higher risk medicines requiring safe custody.
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	4.3	Standard not met	The pharmacy does not always store its medicines safely and in a way which reduces the risk of a mistake occurring. Its monitoring processes are not effective in removing out-of-date medicines from stock.
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 have appropriate monitoring arrangements to help ensure its team members engage in processes designed to reduce risk and share learning following the mistakes they make during the dispensing process. And it does not maintain all of its records as legally required. Its team members work within defined roles. And they keep people's personal information secure. They know how to manage and respond to feedback they receive about the pharmacy's services. And they understand how to act to help keep vulnerable people safe from harm.

Inspector's evidence

The pharmacy had standard operating procedures (SOPs), designed to support its safe and effective running available for team members to refer to. Most team members had signed these SOPs to confirm they had read and understood them. But some new team members, and a temporary team member had not signed the SOPs. The temporary team member demonstrated a good understanding of what tasks could and could not take place in the event the responsible pharmacist (RP) took absence from the pharmacy. Pharmacy team members mostly followed the SOPs when working. For example, completing address checks with people when handing out assembled bags of medicines. And applying their dispensing signatures to medicine labels when assembling and checking medicines. A dispenser worked in an accuracy checking role, known as an accuracy checking dispensing assistant (ACDA). They explained the importance of a pharmacist marking prescriptions to show they had carried out a suitable clinical check of the prescription prior to them completing an accuracy check.

The pharmacy was last inspected in January 2024, since this date it had recorded only seven mistakes on the pharmacy's patient medication record (PMR) system. This raised concerns that efforts made to record and demonstrate learning from mistakes following the last GPhC inspection in January 2024 had not been sustained. The superintendent pharmacist (SI) stated that team members were asked to record their mistakes. They acknowledged that this was not happening in practice. The PMR system showed mistakes that were identified during the dispensing process, known as near misses and mistakes made and identified following the supply of a medicine to a person, known as dispensing incidents. The lack of regular monitoring of mistakes meant the team was missing opportunities to share learning and reduce risk. Stock holding in the dispensary was particularly untidy and this contributed to the risk of a mistake being made.

The pharmacy had a complaints procedure. Its team members knew how to manage feedback and concerns and how to escalate a concern to one of the two pharmacist owners, both owners worked at the pharmacy full-time. Team members were observed being attentive to people's needs and answering queries politely and professionally. The pharmacy had procedures and information available to support its team members in recognising and reporting a safeguarding concern. A team member identified how they would report a safeguarding concern to a pharmacist directly. Both pharmacists had engaged in formal safeguarding learning. And they had access to contact information for local safeguarding teams. 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.

The pharmacy had current indemnity insurance. The RP notice on display contained the correct details of the RP on duty. The owners generally completed the RP record in full when working. But a locum pharmacist working on a Saturday did not always complete the record to show they were on duty. The pharmacy had introduced an electronic controlled drug (CD) register since the last inspection. It maintained running balances within the register. And it undertook regular full balance checks of physical stock against the balances in the register. But some entries were recorded as unexplained balance adjustments. These entries showed receipt or supply of CDs with no supporting information, such as the wholesaler they were received from or the person they had been supplied to. The quantities of the adjustments resulted in the stock balance matching the physical stock. And did not correlate with the usual quantities that were prescribed or supplied. The pharmacy kept a record of the patient-returned CDs it received, and it kept this record up to date. It kept a record of the private prescriptions it dispensed. But these records did not always contain the correct details of the prescriber.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy's team members have the appropriate knowledge and skills required to provide its services. They work together well in a busy environment, and they are supportive of each other. Pharmacy team members engage in some ongoing learning to support them working safely in their roles. And they know how to provide feedback or raise a concern at work.

Inspector's evidence

On duty was the SI, a trainee pharmacy technician, the ACDA, two delivery drivers and three other team members who had recently started working at the pharmacy. The pharmacy's other pharmacist owner arrived partway through the inspection and another dispenser began their shift towards the end of the inspection. The pharmacy employed another three dispensers and a trainee dispenser. It used locum pharmacists to cover pharmacist's days off and leave. Some dispensers had dual roles in providing the pharmacy's delivery service. New members of the team were working through induction learning, one team member was working their first shift at the pharmacy and was reading SOPs. One of the delivery drivers was a temporary driver who was employed to cover leave. The pharmacy currently had a vacancy for an apprentice. Dispensing workload was up to date and team members were observed working well together and supporting each other in resolving queries when they arose.

Team members in training roles felt supported and were able to ask questions to help their learning. A team member currently working through their induction provided examples of how they were supported in their role. Pharmacists monitored team members progress with their learning. Other team members engaged in some ongoing learning relevant to their role. For example, learning to support the safe delivery of the Pharmacy First Service. Communication between team members was largely informal with information shared through conversation. Efforts had been made to start patient safety reviews following the pharmacy's last inspection, but these efforts had not been sustained. This meant there was some missed opportunities to share learning to help reduce risk. The pharmacy did not set specific targets for its services. Its team members knew how to raise a concern at work and were confident in providing feedback to support the pharmacy in delivering its services.

Principle 3 - Premises ✔ Standards met

Summary findings

Overall, the pharmacy premises are suitably maintained and offer an appropriate environment for providing pharmacy services. And people are able to access a private space when having conversations with team members.

Inspector's evidence

The pharmacy premises were secure and maintained to an adequate standard. They were air conditioned, and lighting was sufficient throughout. Team members had access to suitable hand washing facilities and toilet facilities. The owners used local tradespeople to address any maintenance works required. The pharmacy was small for the volume of activity carried out and at the beginning of the inspection work benches were cluttered with baskets of medicines waiting to be accuracy checked. Some unnecessary clutter such as cardboard waste and paperwork was noted. Efforts were made to remove these items shortly after the inspection began which created a safer working environment. Several large boxes full of assembled medicines were held on the dispensary floor. The SI explained the boxes contained bags of assembled medicines waiting for delivery and would be cleared as soon as the drivers arrived, and this was seen to be the case. The baskets on the dispensary workbenches started to clear when the second pharmacist arrived to support workflow. The owners discussed steps they were taking to better manage space. This included an upcoming confirmed change to the dispensing workflow.

The pharmacy consisted of a small public retail area which led to the medicine counter. A private consultation room was available to the side of the public area. But this room was not always immediately available to people as the room was used to store empty plastic boxes waiting for return to wholesalers. The team explained these would be removed to allow access into the consultation room when required. The dispensary was long and narrow, there was a small amount of protected space for completing dispensing activities and a good size workbench for completing accuracy checks of medicines. 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 liquid medicines. These were stored neatly on designated shelves. Two stock rooms at the back of the premises were used to hold further medicines and dispensary sundries.

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

Summary findings

The pharmacy does not fully consider the risks of its medicine storage arrangements. Its stock layout in the dispensary increases the risk of an adverse safety event occurring. And there are out of date medicines in stock. The pharmacy obtains its medicines from licensed sources. Its services are 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 and promotional information about its services. It protected Pharmacy (P) medicines from self-selection by displaying these behind the medicine counter. Pharmacists were able to supervise the activity taking place in the public area from the dispensary. And a trainee team member was observed bringing requests for P medicines directly to a pharmacist's attention. Team members understood the requirement to signpost people to an alternative healthcare provider or pharmacy if required.

Pharmacists were observed supporting team members in resolving queries. And they took the opportunity to speak to people who required advise about minor ailments and their medicines. The pharmacy had some supporting information available to pharmacists providing its NHS consultation services. This included access to service specifications and patient group directions (PGDs) for providing the NHS Pharmacy First service. But evidence that pharmacists had signed the current PGDs for the service was not available. 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. The SI discussed the counselling they provided when supplying medicines requiring people to have pregnancy prevention plans in place. They understood the need for valproate to be dispensed in the manufacturer's original packaging.

Pharmacy team members used baskets throughout the dispensing process to help keep all items for each prescription together. The pharmacy retained prescriptions for the medicines it owed to people. And it used these prescriptions when dispensing owed medicines. The pharmacy delivered a high volume of medicines to people's homes. It used a digital application to support it in planning effective delivery routes. The application provided real-time updates about the status of a delivery should the team receive a query. The pharmacy had a schedule to support team members in managing 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. They did not contain descriptions of the medicines inside the pack routinely, but these were provided when indicated on people's individual profile sheets. The pharmacy supplied patient information leaflets (PILs) at the beginning of every four-week cycle of compliance packs. A team member explained that sometimes the team would highlight the description section of the PIL to support people in recognising their medication.

The pharmacy sourced medicines from licensed wholesalers. It stored medicines in their original packaging and it had increased the space it used to store medicines since the last inspection. In doing

this it had created an extra storeroom. This room was warm, and the temperature was not monitored. The SI stated they would obtain a thermometer to assure themselves the room was suitable for storing medicines. Medicines stored in another stock room were held on shelves in an orderly manner. But stock within the dispensary was disorganised with different medicines mixed up. These storage arrangements, along with the lack of insight into near misses and dispensing incidents increased the risk of a mistake occurring when team members picked medicines. The pharmacy stored its CD medicines in secure cabinets. And medicines in the cabinets were stored in an orderly manner. The pharmacy's fridge was a suitable size for the medicines it held. And the pharmacy kept fridge temperatures to assure itself the medicines inside were kept within the required temperature range of two and eight degrees Celsius.

Pharmacy team members explained they undertook checks of pharmacy stock, such as expiry dates when the pharmacy was quiet. But they did not record the checks they made routinely. A random check of stock found several date expired medicines in the pharmacy's fridge. These medicines were segregated and brought to the attention of the SI for safe disposal. Team members annotated opening dates on liquid medicines to help them make checks that any medicine remaining in the bottle was safe to supply. The pharmacy had medicine waste receptacles, and these were collected regularly by a waste contractor. It had CD denaturing kits available for the secure destruction of CDs. The SI demonstrated the receipt of safety alerts and recalls about medicines through email. The team maintained an audit trail of the checks they made for these alerts.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it requires 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 accessed digital reference resources and the internet to help them resolve queries and obtain 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 medicines 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 mostly used standardised counting and measuring equipment when dispensing medicines. But one plastic measuring cylinder did not bear any mark to show it was calibrated to measure accurately. The SI acknowledged this and stated they would order a new standardised measure to replace the plastic one. The pharmacy had equipment available to support its NHS consultation services, this was from recognised manufacturer's and was clean and available for use. 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.