General Pharmaceutical Council

# Registered pharmacy inspection report

**Pharmacy Name:** G. Payne (Chemists) Ltd., 8 High Street, Kirton Lindsey, GAINSBOROUGH, Lincolnshire, DN21 4LU

**Pharmacy reference:** 1034250

**Type of pharmacy:** Community

**Date of inspection:** 01/11/2022

## Pharmacy context

The pharmacy is in a small, rural town in Lincolnshire. Its main services include dispensing NHS prescriptions, selling over-the-counter medicines and providing health advice to people. 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 to people's 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. It keeps people's confidential information secure. And it generally keeps the records it must by law. The pharmacy advertises how people can provide feedback about its services. And its team members understand act on this feedback appropriately. Pharmacy team members understand how to recognise and respond to safeguarding concerns. And they engage in some conversations to help reduce risk following mistakes made during the dispensing process.

### Inspector's evidence

The pharmacy had a range of standard operating procedures (SOPs) designed to support its safe and effective running. There was evidence of all team members, including the responsible pharmacist (RP) and superintendent pharmacist (SI) refreshing their understanding of the SOPs every few years. But there was no record of a formal review of the SOPs taking place since their implementation in 2015. There was evidence of new SOPs being introduced to reflect changes in the services provided by the pharmacy. For example, SOPs relating to managing needle stick injuries and biohazard incidents had been introduced to support the safe running of the flu vaccination service. SOPs clearly identified team members roles and responsibilities. And members of the pharmacy team on duty demonstrated their roles with competence. A team member explained what tasks could not be completed if the RP took absence from the pharmacy, and another discussed the importance of referring repeat requests for over-the-counter medicines subject to abuse, misuse, and overuse to a pharmacist.

Pharmacy team members engaged in some learning following mistakes made and identified during the dispensing process, known as near misses. This commonly involved discussing and correcting their mistake, and reflecting on the cause of the mistake. The team reduced risk by separating similar-looking medicines and medicines whose names sounded alike. But the team did not always take the opportunity to record near misses within its near miss record. And where a mistake was recorded, the team used the action section of the near miss record to record immediate steps taken to correct the mistake, rather than the action taken to reduce future risk. This meant that it could be more difficult for the team to measure how effective its actions were in reducing risk. The pharmacy recorded dispensing incidents. And incident report forms included a summary of the event, contributory causes and actions taken to reduce risk.

The pharmacy had a complaints procedure. And it advertised details of how people could provide feedback or raise a concern about the pharmacy. A trainee team member provided evidence of learning associated with responding to concerns and feedback. And another team member discussed how they would manage a concern, and escalate the matter to a pharmacist if required. The pharmacy had procedures to support its team members in handling personal information with care. It stored personal identifiable information in staff only areas of the pharmacy. Pharmacy team members disposed of confidential waste securely. They had completed learning and had engaged in discussions about the importance of protecting vulnerable people. The pharmacy had supportive information available to assist its team members in reporting a safeguarding concern. And it prominently advertised that it offered a safe space to members of the public suffering domestic abuse. A team member provided an example of how pharmacists worked with other healthcare providers to support people in taking their

medicines safely.

The pharmacy had up-to-date indemnity insurance arrangements. The RP notice displayed the correct details of the RP on duty. A sample of the RP record, Prescription Only Medicine (POM) register, and CD record generally met legal requirements. A private prescription dispensed in September 2022 had not been entered into the POM register as required. And page headers were not completed on every numbered page of the CD register. The pharmacy maintained running balances in its CD register. And there was evidence of regular physical balance checks of stock taking place against the register. A random physical balance check conducted during the inspection complied with the running balance in the register. The pharmacy had a patient returned CD destruction register, but the team did not always record returns in the register at the point of receipt.

## Principle 2 - Staffing ✔ Standards met

### Summary findings

The pharmacy has enough team members to manage its workload effectively. It supports a learning environment, allowing team members to develop their knowledge and skills. Pharmacy team members demonstrate enthusiasm for their roles. They understand how to provide feedback and raise concerns at work. And they are confident in sharing their thoughts and ideas.

### Inspector's evidence

The RP worked at the pharmacy three days a week and the SI worked the other three days each week. The pharmacy employed two qualified dispensers, a qualified medicine counter assistant (MCA), two trainee dispensers and a trainee MCA. There was a current vacancy for a qualified dispenser advertised. Team members reported working flexibly to cover both planned and unplanned leave. The pharmacy had a number of trainees, including one of the qualified dispensers who had progressed to the role of pre-registration pharmacy technician. Team members did receive some learning time in work, but this time was not always protected due to workload increasing.

Both trainee dispensers were on duty throughout the inspection, and there was a clear learning environment to support them in completing tasks safely and efficiently. They were confident in asking questions and referring to the pharmacist when needed. The RP made themselves available to answer queries and create learning opportunities for team members. For example, a prescription calling for an antibiotic reconstitution became a learning session about how to measure water for the reconstitution by looking at the measure at eye level and reading the bottom point of the meniscus. The pharmacy did not have a structured appraisal process. But there was evidence of monitoring related to learning and development. For example, one trainee was currently undertaking labelling and stock management tasks in the dispensary before moving on to begin picking and assembling medicines.

The pharmacy team was working towards a current target of introducing the NHS hypertension case-findings service. And work had commenced on scoping the requirements for the service. For example, the need to have an ambulatory blood pressure machine. Pharmacy team members were confident when explaining how they could provide feedback or share ideas at work. For example, a team member had put forward an idea to support stock management checks of the retail area. And they were in the process of creating new forms to support with these checks. The pharmacy had a whistle blowing policy. Pharmacy team members knew how to raise and escalate a concern at work. They provided examples of how they felt well supported at work. Communication within the team was generally provided through informal discussions across the working day. But team members did not engage in regular, structured meetings to help share learning.

## Principle 3 - Premises ✔ Standards met

### Summary findings

The pharmacy premises are clean and secure. They provide an appropriate space for the delivery of healthcare services. People using the pharmacy can speak with a member of the pharmacy team in a private consultation room.

### Inspector's evidence

The premises were located in a conservation area and as such were in keeping with the traditional style of other local buildings. They were secure and maintained to an adequate standard. There was one outstanding maintenance issue waiting to be dealt with following some water damage caused by recent heavy rain. The damage was in an area of the pharmacy accessed by staff only, and access was currently restricted until the issue was resolved. The team reported that the SI managed maintenance concerns through the use of local tradespeople. Lighting throughout the pharmacy was appropriate as was heating and ventilation. Working areas were clean and free of trip and fall hazards. Pharmacy team members had access to hand washing facilities. And pharmacists providing the flu vaccination service accessed a sink equipped with antibacterial soap and paper towels, located close to the staff entrance of the consultation room.

The premises consisted of a good size public area. There was a table positioned mid-way into this area which acted as a reception desk. This effectively supported pharmacy team members in managing infection control risks when working during a pandemic. The dispensary was to the side of the medicine counter, and was a long galley-style room. There was adequate space for completing dispensing tasks, and a room off the dispensary provided additional bench space for completing some higher-risk tasks. For example, assembling medicines in multi-compartment compliance packs. Beyond the medicine counter was a clearly signposted consultation room. The room was an appropriate size for completing private consultations and it was clean and relatively organised. To the back of the premises there was staff facilities and a storage area used primarily to hold old equipment and sundries.

## Principle 4 - Services ✔ Standards met

### Summary findings

The pharmacy's services are accessible to people. It obtains its medicines from reputable sources. And it generally stores its medicines safely and securely. Pharmacy team members engage people in conversations about their health and their medicines. But they do not supply information leaflets when dispensing some medicines. This may on occasion limit the information people have available to support them in taking their medicines safely.

### Inspector's evidence

People accessed the pharmacy via a step from street level, through a simple latch door. The pharmacy clearly advertised its opening times and details of its services for people to see. Team members supported people with access into the pharmacy when required. And they occasionally served people at the entrance to the pharmacy. Most team members, including pharmacists provided the medicine delivery service. This provided people with an opportunity to speak face-to-face with a pharmacist in their own environment.

There was a prominent health promotion zone close to the entrance of the pharmacy. Current topics focussed on reducing alcohol consumption, maintaining a healthy blood pressure, and giving up smoking. The pharmacy also prominently promoted an inhaler recycling service, and had a drop-off bin available close to its entrance. This encouraged people to return their used inhalers for safe disposal, and reduced the harmful environmental impact associated with landfill disposal. Pharmacy team members understood the need to signpost people to other pharmacies or healthcare providers should they be unable to provide a service or supply a medicine. Pharmacists had access to up-to-date patient group directions (PGDs) to support the safe delivery of the flu vaccination service. And team members accessed the most recent version of the local Minor Ailment Service formulary electronically. The pharmacy protected Pharmacy (P) medicines from self-selection by displaying them behind the medicine counter. And pharmacists could supervise activity in the public area adequately.

The pharmacy identified higher-risk medicines during the dispensing process by using 'pharmacist information forms'. The team used the forms to highlight key messages such as changes in doses or formulations of medicines and the presence of cold-chain medicines or CDs requiring retrieval. They also indicated the need for pharmacist counselling upon handout of the medicine. The team attached the forms to assembled bags of medicines to help inform the safe supply of the medicine. The RP explained that verbal counselling associated with the supply and monitoring of higher-risk medicines took place regularly. People were encouraged to telephone the pharmacy with the results from recent monitoring checks if they did not have these with them. And the team recorded these checks on the patient medication record (PMR). The RP understood the requirements of the valproate Pregnancy Prevention Programme (PPP). But some resources to support people taking these medicines such as the patient guide was not readily available to issue to people within the at-risk group. The RP confirmed the pharmacy did not currently dispense valproate to a person within the at-risk group. And provided examples of historic checks and counselling undertaken previously when it had dispensed to these people.

The pharmacy kept each person's prescription separate throughout the dispensing process by using

tubs. And there was a clear system to manage owed medicines. This included identifying out-of-stock medicines and communicating with prescribers to update them of current stock issues. The pharmacy maintained an electronic audit trail of the medicines it delivered by marking deliveries on the PMR. It asked people to sign for the receipt of CDs, this form included a statement confirming the person acknowledged the need to keep their medicines in a safe and secure place. Pharmacy team members generally signed the 'dispensed by' and 'checked by' boxes on medicine labels to form a dispensing audit trail. But they did not normally complete this audit trail when supplying medicines in multi-compartment compliance packs. And the pharmacy did not routinely provide patient information leaflets (PILs) when supplying medicines in this way. A discussion highlighted the requirement to provide a PIL when supplying a medicine. The pharmacy used individual record sheets to record details of people's medication regimens. It updated these records and retained supportive information when there was a change to a person's medication. For example, it retained hospital discharge summaries with the record sheet. A sample of assembled compliance packs contained clear descriptions of the medicines inside to help people identify them.

The pharmacy sourced medicines from licensed wholesalers and specials manufacturers. It stored medicines in their original packaging in an orderly manner. The pharmacy stored medicines subject to safe custody arrangements appropriately in secure cabinets. Storage of medicines within the cabinets was organised. It had two clean medical fridges for the storage of cold-chain medicines. Both fridges were nearing their storage capacity. The RP explained this was in the process of being reviewed with the potential of adding an additional fridge. Medicines inside were held in an orderly manner. The pharmacy monitored its fridge temperatures and recorded these daily (Monday-Saturday). The records showed both fridges were operating within the accepted temperature range of two and eight degrees Celsius.

The pharmacy kept some evidence of the date checking tasks its team members completed. But the RP felt that sometimes checks may be made and not recorded. Team members confirmed they completed date checking tasks regularly during quieter periods. There was some out-of-date General Sales List (GSL) medicines and P medicines held to the side of the medicine counter. A team member confirmed these were waiting for safe disposal, and they did not risk being mixed up with stock. A random check of dispensary stock did find several out-of-date medicines. Some of these were highlighted with details of their expiry date to prompt additional checks during the dispensing process. Team members did not routinely check expiry dates when picking and assembling medicines. This meant there was a reliance on the pharmacist's accuracy checking process to identify an out-of-date medicine. Liquid medicines were clearly marked with details of their opening dates to ensure they remained safe and fit to supply. The pharmacy had medicine waste bins available to support the safe disposal of medicine waste. It received medicine alerts by email through the NHS Central Alerting System and it kept an electronic audit trail of these alerts.

## Principle 5 - Equipment and facilities ✔ Standards met

### Summary findings

The pharmacy has the equipment and facilities it needs to provide its services. And pharmacy team members act with care by using the equipment in a way which protects people's confidentiality.

### Inspector's evidence

The pharmacy had up-to-date written reference resources available including the British National Formulary (BNF). Team members had access to the internet to support them in obtaining up-to-date information. The pharmacy's computer system was password protected. And information displayed on computer monitors was suitably protected from unauthorised view. The pharmacy stored bags of assembled medicines in the dispensary and behind a protected screened area, close to the entrance of the dispensary. This arrangement protected people's private information.

The pharmacy had clean equipment available for counting and measuring medicines. It highlighted equipment for measuring and counting higher-risk medicines. This helped to reduce any risk of cross contamination. A range of consumables and equipment to support the flu vaccination service was available within the consultation room. The pharmacy used a modern blood pressure machine from a reputable manufacturer. Pharmacists used the machine to offer a screening service only. Electrical equipment was visibly free of wear and tear and in good working order.

## 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. |