

Registered pharmacy inspection report

Pharmacy Name: Mr Pickford's Pharmacy, 75 St. Johns Road,
KETTERING, Northamptonshire, NN15 5AZ

Pharmacy reference: 1035436

Type of pharmacy: Community

Date of inspection: 19/05/2021

Pharmacy context

This is a community pharmacy situated in a small row of shops in a Kettering suburb. 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 the substance misuse service, the Discharge Medicines Service, and delivering medicines 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 adequately identifies and manages the risks associated with the provision of its services. Its team members have defined roles and accountabilities. The pharmacy manages people's personal information safely. It knows how to protect vulnerable people. The pharmacy mainly has adequate procedures to learn from its mistakes. But it doesn't always make records about mistakes so it could be missing opportunities to learn from them.

Inspector's evidence

The pharmacy had a set of up-to-date standard operating procedures (SOPs). They had been read by the pharmacy team who mainly followed them. For example, the staff were observed following the SOP relating to dispensing medicines. The counter assistant had a good understanding of how to sell medicines safely. She knew that she couldn't work in the dispensary. 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. She said that prescriptions waiting collection that contained a CD were highlighted to make staff aware. When this was checked there were some that were not highlighted. The pharmacy manager said that she would remind staff to highlight them.

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 then recorded in a near miss log. The near miss log was reviewed. Learning points and action taken that were recorded in the near miss log had limited explanations. The pharmacy had been regularly recording near misses up until the last few weeks but records since then had been erratic. The pharmacy manager said the regular pharmacist, who usually recorded the near misses in the near miss log, had not been at the pharmacy over this period. The pharmacy manager said that she would speak to the team and remind them that recording near misses was the responsibility of the whole of the team.

The pharmacy maintained appropriate legal records to support the safe delivery of pharmacy services. These included the responsible pharmacist (RP) log, the CD registers and the private prescription record. Records showed that CD running balances were usually regularly audited. But recently this had been less regular. The pharmacy manager said that she would make sure that balance checks were regularly carried out. Patient- returned CDs were recorded in accordance with requirements. Dispensed CDs waiting collection in the CD cupboard were clearly separated and the corresponding prescriptions were in date.

The pharmacy had appropriate professional indemnity insurance. 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 paperwork was stored securely. Confidential waste was disposed of in separate confidential waste bins and sent to head office for destruction. The pharmacist was aware of safeguarding requirements; there were local contact details available.

Principle 2 - Staffing ✓ Standards met

Summary findings

The pharmacy's team members work well together and adequately manage the workload within the pharmacy. They are suitably trained, or on appropriate training courses, for the roles they undertake. Team members can raise concerns if needed.

Inspector's evidence

The pharmacy displayed who the RP in charge of the pharmacy was. The RP record showed who the RP in charge of the pharmacy had been. The pharmacists didn't always sign out of the record which created an incomplete audit trail.

During the inspection the pharmacy team adequately managed the day-to-day workload. Some of the pharmacy team had recently changed which meant that some activities hadn't always run as smoothly as they might. On the day of the inspection the pharmacy had dispensing support from a dispenser from another branch because of staff absence and a vacancy. A locum pharmacist, two dispensing assistants and one counter assistant were present. There was an annual formal appraisal and staff said they could raise concerns if necessary. Staff said that training was mainly done at home.

Principle 3 - Premises ✓ Standards met

Summary findings

The pharmacy keeps its premises safe, secure and appropriately maintained. The pharmacy makes changes to help keep staff and people using the pharmacy safe during the pandemic.

Inspector's evidence

The pharmacy presented a bright modern image. There was an automatic entrance door but there was also a step into the pharmacy from outside making access more difficult for people with a physical disability or with young children in a pushchair. The public area was a reasonable size. The dispensary was a suitable size for the services provided. The pharmacy had air conditioning providing an appropriate temperature for the storage of medicines; lighting was sufficient. There was a sink with hot and cold water.

A reasonable size sound-proofed secure consultation room was available but wasn't currently being used. Dispensed medicines awaiting collection were stored behind a small curved wall between the consultation room and the public area. There was a curtain across the area which meant that the address labels on the bags containing dispensed medicines weren't visible as patients left the consultation room.

The pharmacy had appropriate processes in place to support safe working during the Covid-19 pandemic. The pharmacy restricted access into the pharmacy although the lack of a sign highlighting the number of people allowed in meant that when the inspector arrived people waited outside the pharmacy when there was only one person in the pharmacy. There was counter to ceiling clear plastic screening at the pharmacy counter to provide re-assurance to both the staff and the customers. There was hand sanitiser available. The pharmacy was cleaned daily. The pharmacy team had all been vaccinated and were having twice weekly Covid-19 lateral flow tests. They reported the results to NHS England. The team wore masks apart from one member of staff who had an exemption. Unauthorised access to the pharmacy was prevented during working hours and when closed.

Principle 4 - Services ✓ Standards met

Summary findings

The pharmacy offers healthcare services which are generally well managed and are accessible to people. 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 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 pharmacy staff were helpful and tried to resolve problems for people visiting the pharmacy. The pharmacy team understood the signposting process and the experienced staff used local knowledge to direct people to local health services. 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. 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. The pharmacy aimed to highlight prescriptions with these medicines so that when people collected them they could be given advice. But in practice this was not always done. This meant that some people may not always have received up-to-date information about the medicines they were taking. The pharmacy manager said she would review the process.

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. The pharmacy now sent prescriptions for multi-compartment compliance packs and most regular monthly repeat prescriptions to the pharmacy hub for assembly. The pharmacy manager said that this worked well and had reduced pressure at the pharmacy. The compliance packs seen had the colour and shape of medicines recorded to make them easily identifiable, and patient information leaflets were sent monthly.

Medicines were stored on shelves tidily and in original containers. Most bottles had the dates that they had been opened recorded. Date checking was carried out regularly. A sample of medicines checked were in date. The pharmacy only used recognised wholesalers to supply them with medicines. The pharmacy delivered medicines to some people. The person delivering the prescription maintained appropriate distance due to the pandemic. The pharmacy had a procedure for managing drug alerts.

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. Records showed that the fridge was in working order and stored medicines within the required range of 2 and 8 degrees Celsius. CDs were stored appropriately. Records showed that portable electrical equipment had not been recently safety tested. The pharmacy manager said this was because of Covid-19. 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.