General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Well, Ecton Brook Road, NORTHAMPTON, Northamptonshire, NN3 5EN

Pharmacy reference: 1035450

Type of pharmacy: Community

Date of inspection: 12/09/2024

Pharmacy context

The pharmacy is situated next door to a GP surgery. Most of its activity is dispensing NHS and private prescriptions and selling medicines over the counter. It provides NHS services such as the 'Pharmacy First' service, the Hypertension case-finding service and Contraception service.

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 the provision of its services. And the pharmacy keeps the records it needs to by law. The pharmacy manages people’s electronic personal information safely. The pharmacy has some procedures to learn from its mistakes.

Inspector's evidence

The pharmacy had a set of electronic standard operating procedures (SOPs) which were routinely updated by the pharmacy's head office. After team members had read a SOP, they completed a test to make sure they had understood it. Staff were seen dispensing medicines and handing medicines out to people safely. Staff understood how to sell medicines safely and the advice to give during a sale. Staff knew that prescriptions were valid for six months apart from some controlled drugs (CDs) which were valid for 28 days. Prescriptions containing CDs were highlighted to remind staff of their shorter validity. Team members wore uniforms and were easily identifiable with name badges.

The pharmacy had processes for learning from 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 then recorded in the electronic near miss log. A member of staff who was not present reviewed the near misses and the outcomes were discussed in team meetings. It was not possible to review the electronic near miss records because no one in the pharmacy knew how to access the dashboard.

The correct responsible pharmacist (RP) certificate was on display. The pharmacy mainly maintained the necessary records to support the safe delivery of pharmacy services. These included the RP record, the private prescription book, and the CD register. The entries for two items in the CD register checked at random during the inspection agreed with the physical stock held. Balance checks were completed weekly. Patient-returned CDs and date-expired CDs were clearly marked and separated from stock CDs to prevent dispensing errors. There were some patient-returned CDs in the CD cupboard that had not been entered in the register. This increased the risk of diversion. The pharmacist said she would enter them in the patient-returned CD register. A dispensed CD that was beyond its 28-day validity was still in the cupboard. This increased the risk that it could be handed out by mistake.

The pharmacy had a complaints procedure and an information governance policy. Access to the electronic patient medication record (PMR) was password protected. Confidential information was stored and destroyed securely. Professional indemnity insurance was in place. The pharmacy team had completed appropriate safeguarding training for their role and could explain the actions they would take to safeguard a vulnerable person.

Principle 2 - Staffing ✔ Standards met

Summary findings

There are enough team members to manage the pharmacy’s workload. They are suitably trained or in training for the roles they undertake. Team members can raise concerns if needed.

Inspector's evidence

During the inspection, the pharmacy team managed the day-to-day workload of the pharmacy effectively. There was one pharmacist and three trained dispensers. The team members supported each other, helping each other out when necessary. Team members were observed referring queries to the pharmacist when needed. Staff said they felt supported by the manager and the pharmacist. They discussed any issues informally on a daily basis and felt able to raise concerns if necessary. The team had access to online training and were also given ad hoc informal training from the pharmacist.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy keeps its premises safe, secure, and appropriately maintained. And people visiting the pharmacy can have a conversation with a team member in private.

Inspector's evidence

The public area in front of the pharmacy counter was a good size. The dispensary was a little small for the services provided. Storage was a little limited which meant that some items, such as tote boxes and dispensing baskets were on the floor during the inspection. This increased the risk of someone tripping over them. The premises were clean and well-lit. There was air conditioning to maintain a suitable temperature for storing medicines. Hot and cold running water was available. One reasonable sized consultation room was available for people to have a private conversation with pharmacy staff. Unauthorised access to the pharmacy was prevented during working hours and when closed.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's healthcare services are suitably managed and are accessible to people. The pharmacy gets its medicines and medical devices from reputable sources. It stores them safely and team members know the right actions to take if medicines or devices are not safe to use to protect people’s health and wellbeing.

Inspector's evidence

The pharmacy had a ramp and an automatic door which provided good access for people with a disability or a pushchair to get into the pharmacy. The pharmacy team understood the signposting process and used local knowledge to direct people to local health services. Pharmacy medicines were stored out of reach of the public and staff were aware of higher-risk, over-the-counter medicines such as painkillers containing codeine. The pharmacy team knew the advice about pregnancy prevention that should be given to people in the at-risk group who took sodium valproate and had implemented the latest advice. The pharmacist gave a range of advice and support to people using the pharmacy's services. She highlighted how she had recently made sure that a person who had left hospital got their correct medicines through the discharge medicine service. She gave advice when people had a new medicine or if their dose changed but did not always check that people who were getting medicines that required ongoing monitoring such as methotrexate or warfarin were receiving these checks. She said going forward she would check.

The pharmacy was providing the NHS ‘Pharmacy First’ services. This allowed the pharmacy to treat seven common conditions including supplying prescription-only medicines. The pharmacist had completed the required training and had signed the accompanying patient group directions (PGDs). The pharmacy was proactively offering the hypertension case-finding service; stickers were placed on prescriptions so that team members handing out prescriptions knew who to speak to. The pharmacist said that they had found people with undiagnosed hypertension who had been prescribed medicines for hypertension when referred to their GP. The pharmacy team members said they had received positive feedback about these services.

The pharmacy used a dispensing audit trail which included use of 'dispensed by' and 'checked by' boxes on the medicine label to help identify who had done each task. Baskets were used to keep medicines and prescriptions for different people separate to reduce the risk of error. The pharmacy supplied medicines in multi-compartment compliance packs to a small number of people living in the community to help them take their medicines at the right time. Compliance packs seen did not include complete medicine descriptions on the packs which could make it harder for people to identify individual medicines in their packs. Patient information leaflets were provided to people each month.

Some medicines were dispensed at an automated hub as part of the company's central fulfilment programme. Before transmission to the hub, the pharmacist was required to complete an accuracy check of the computer data and a clinical check of the prescription. Dispensed medicines were received back from the hub within 24-48 hours.

Medicines were stored on shelves in their original containers. Some of the shelves were untidy with different strengths of a medicine mixed-up. This increased the risk that the wrong strength of a

medicine would be picked. Opened bottles of liquid medications were marked with the date of opening so that the team would know if they were still suitable for use. Medicines in the fridges were kept neatly and tidily in baskets. The pharmacy team had a process for date checking medicines. A check of a small number of medicines did not find any that were out of date. CDs were stored appropriately. A record of invoices showed that medication was obtained from licensed wholesalers. The pharmacy manager explained the process for managing drug alerts which included a record of the action taken.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs for the services it provides. It maintains its equipment so that it is safe to use.

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. The pharmacy's portable electronic appliances had been last tested in February 2024 to make sure they were safe.

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.