General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Porlock Pharmacy, Doverhay, Porlock, MINEHEAD, Somerset, TA24 8PT

Pharmacy reference: 1036332

Type of pharmacy: Community

Date of inspection: 28/03/2023

Pharmacy context

The pharmacy is located in Porlock, a village near Minehead. It sells over-the-counter medicines and dispenses NHS and private prescriptions. And it delivers medicines to people's homes. The pharmacy team offers advice to people about minor illnesses and long-term conditions. The pharmacy offers services including flu vaccinations, the NHS New Medicine Service (NMS) and the Community Pharmacy Consultation Service (CPCS). It also supplies medicines in multi-compartment compliance aids to people living in their own homes.

Overall inspection outcome

✔ **Standards met**

Required Action: None

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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 takes appropriate steps to identify and manage its risks. Team members record any mistakes they make and analyse why they happened. The pharmacy team then makes the necessary changes to stop mistakes from happening again. The pharmacy completes a regular review of errors. But this is not always documented, which may mean that opportunities to identify trends and learn from them are lost. The pharmacy has appropriate written procedures in place to help ensure that its team members work safely. The pharmacy responds appropriately when it receives feedback. It has the required insurance in place to cover its services. And it keeps all the records required by law. The pharmacy keeps people's confidential information safe and explains how it will be used. Pharmacy team members know how to protect the safety of vulnerable people.

Inspector's evidence

The pharmacy had written standard operating procedures (SOPs) which reflected the way the team worked. Each team member had signed paper copies of the SOPs to demonstrate that they had read and understood them. The pharmacy team could describe the activities that could not be undertaken in the absence of the responsible pharmacist (RP). Team members had clear lines of accountabilities and were clear on their job role. The pharmacy had risk assessments in place to cover its activities. And it had a business continuity plan.

Pharmacy team members generally recorded any mistakes they made which were identified during the final accuracy check, known as near misses, on a paper log. The responsible pharmacist (RP) reviewed the errors regularly, although this was not always documented or shared with all team members. When errors occurred, the pharmacy team discussed them and made changes to prevent them from happening again. Some medicines that had similar sounding names and strengths were separated on the shelves. The RP, a locum who worked in the branch one day each week, was planning to place red tape on the shelves and drawers where high-risk medicines and those that looked or sounded like others were stored. He hoped that this would reduce the chance that they were selected incorrectly. The pharmacy reported any mistakes that reached the patient on a national reporting database. The pharmacy team analysed these incidents in much more detail to understand why they had happened.

The pharmacy had a documented procedure in place for handling complaints or feedback from people. There was information displayed in the retail area about how to provide the pharmacy with feedback. Any complaints were dealt with promptly by the regular pharmacist and passed to the area manager if needed. Public liability and professional indemnity insurances were in place.

The pharmacy kept a written record of who had acted as the RP each day. The correct RP notice was prominently displayed. Controlled drug (CD) registers were in order. But there was no evidence that balance checks were completed. The superintendent pharmacist later clarified by email that he checked the balances of CDs as they were dispensed and annotated the register with a tick to show that the task had been completed. Two random balance checks were accurate. Patient returned CDs were recorded in a separate register and were segregated in the CD cabinet.

Appropriate records of private prescriptions were made in a private prescription book. The pharmacy kept records of the receipt and supplies of unlicensed medicines ('specials'). Certificates of conformity

were annotated with the details of the supply. They were stored for the required length of time.

All team members completed yearly training on information governance and the general data protection regulations. Patient data and confidential waste were dealt with in a secure manner to protect privacy and no confidential information was visible from customer areas. Team members ensured that they used their own NHS smart cards. Verbal consent was obtained before summary care records were accessed.

All team members were trained to an appropriate level on safeguarding. The RP had completed the Centre for Postgraduate Pharmacy Education (CPPE) level 2 safeguarding training. Local contacts for the referral of concerns were available online. Team members were aware of signs of concerns requiring escalation.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough team members to manage its workload. Team members complete appropriate training for their roles and keep their skills up to date. They are confident to suggest and make changes to the way they work to improve their services. The team work well together, communicate well and support each other to deliver the pharmacy's services.

Inspector's evidence

On the day of the inspection, the RP was a locum pharmacist. He had recently been working in the pharmacy regularly to cover the regular pharmacist's day off. The regular pharmacist was the superintendent pharmacist (SI) of the small chain the pharmacy was part of. There were four part-time dispensers, one of whom was a trainee. At the start of the inspection there were two dispensers working in the pharmacy, one of whom had recently retired but had agreed to work to cover sickness. Towards the end of the inspection, they finished their shifts and were replaced by another two dispensers.

The pharmacy team said that they coped well with the workload. Dispensing was up to date and prescriptions were generally ready when people arrived to collect them. The team communicated well with each other and were happy to discuss ways to improve how they worked. Team members covered each other's absences by increasing their hours and swapping shifts. In an emergency, team members from a nearby branch of the chain could offer additional support.

Of the four employed dispensers, three had completed accredited dispensing courses. The fourth was currently working through the course. They were given time to learn at work. And they were supported by the rest of the pharmacy team. All team members ensured they completed any training on different conditions and new products. They were seen to give appropriate advice when selling medicines over the counter. They referred to the pharmacist for additional advice as needed.

The RP said that there were no specific targets set in the pharmacy. Team members were aware of the internal escalation process for concerns and a whistleblowing policy was in place.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is generally a suitable environment for people to receive healthcare services. But the location of the consultation room may mean that some people cannot access additional services or receive confidential advice. The pharmacy is tidy, clean and secure.

Inspector's evidence

The pharmacy was located on the high street of Porlock, Somerset. There was a retail area which led to the healthcare counter. To the side of the counter was the main dispensary, which was small but well organised. Stock was stored on shelves and in drawers. A staircase within the dispensary led to a second dispensary upstairs, which was used to dispensed medicines in multi-compartment compliance aids and to store excess stock. The consultation room was also upstairs, along with other office space and staff facilities.

In order to access the consultation room, people needed to walk into the dispensary and up the stairs. As completed prescriptions were stored on that route, there was a chance that people's private information could be seen. The RP said that the consultation room was not used very often, but it had been used regularly during the flu season. There was no provision for people with disabilities to have private consultations.

The retail area was very well presented, the pharmacy's fixtures and fittings were nostalgic which was in keeping with the history of the building and area. All public were clean, and the pharmacy was suitably lit and well-ventilated. The upstairs office was cluttered. But the dispensing area was organised with clear benches. Cleaning was undertaken each day and a cleaning rota was displayed. Cleaning products were available, as was hot and cold water.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy team make sure that people with different needs can access its various services. The pharmacy supplies medicines safely to people with appropriate advice to ensure they are used correctly. Team members take steps to identify people prescribed high-risk medicines to ensure that they are given additional information. The pharmacy obtains its medicines from reputable suppliers and stores them securely. The pharmacy accepts unwanted medicines and disposes of them appropriately.

Inspector's evidence

The pharmacy was accessed by a small step. There was a doorbell which people could use to alert team members that they needed help. Team members also served people at the door if needed. The pharmacy could provide additional support for people with disabilities, such as producing large print labels. A range of health-related posters and leaflets were displayed. Team members explained that if a person requested a service not offered by the pharmacy at the time, they referred them to other nearby pharmacies or providers, calling ahead to ensure the service could be provided there. Up-to-date signposting resources and details of local support agencies were accessed online.

The pharmacy had a clear flow to ensure prescriptions were dispensed safely. Team members used baskets to store dispensed prescriptions and medicines to prevent transfer between patients as well as to organise the workload. There were designated areas to dispense and accuracy check prescriptions. Team members initialled the labels of medicines when they dispensed and checked them.

Coloured stickers were used to highlight prescriptions containing fridge items and CDs in schedules 2 and 3. The RP described that they checked if patients receiving lithium, warfarin and methotrexate had had blood tests recently, and gave additional advice as needed. And they made records of this advice on the PMR. They also made records of other interventions made, such as when prescribing errors were identified.

The pharmacy had a health promotion zone and provided advice to people on living healthy lifestyles. The pharmacy was registered to receive referrals as part of the Community Pharmacy Consultation service (CPCS) and received regular referrals, from both NHS111 and the GP practice. The pharmacy offered a minor ailments service and administered a small number of flu vaccinations. The patient group directions (PGDs) had been printed and signed by those pharmacists providing the service.

The pharmacy team was aware of the risks associated with people becoming pregnant whilst taking sodium valproate as part of the Pregnancy Prevention Programme (PPP). The pharmacy team took care not to apply labels over the warning cards on the boxes of valproate products when dispensing. There were stickers for staff to apply to valproate medicines dispensed out of original containers to highlight the risks of pregnancy to people receiving prescriptions for valproate. The pharmacists had completed an audit to identify those people at risk who were prescribed valproate to ensure they were on adequate contraception.

Multi-compartment compliance aids were prepared by the pharmacy for people living in their own homes. Each person had been assessed to ensure that compliance aids were the most appropriate option. The workload was organised and well planned. A sample of compliance aids was inspected.

Each compliance aid was clearly labelled. Team members signed to show who had dispensed and checked the compliance aid. And they wrote a description of the tablets included so that they could be easily identified. Patient information leaflets (PILs) were supplied each month. Medicines prescribed to be taken 'when required' were dispensed in boxes. A record of any changes made was kept on a patient information sheet, which was available for the pharmacist during the checking process.

The dispensary stock was generally arranged alphabetically on shelves. It was mostly well organised. Date checking was undertaken regularly and records were kept. Spot checks revealed no date-expired medicines or mixed batches. Prescriptions containing owings were appropriately managed, and the prescription was kept with the balance until it was collected. The pharmacy had experienced shortages of some common medicines. This was a reflection of the situation across the country. Team members placed orders several times throughout the day and tried to keep people informed of the estimated date that owing medicines would be available. Stock was obtained from reputable sources. Records of recalls and alerts were actioned promptly. Relevant alerts were printed and stored with any quarantined stock.

CDs were stored in accordance with legal requirements in an approved cabinet. A denaturing kit was available so that any CDs awaiting destruction could be processed. Expired CDs were clearly marked and segregated in the cabinet. Patient returned CDs were recorded in a register and destroyed in the presence of a witness. The dispensary fridge was clean, tidy and well organised and records of temperatures were maintained. The maximum and minimum temperatures were within the required range.

Logs were kept of deliveries made to people in their own homes. The delivery driver described the process followed in the event of failed deliveries to ensure that patients received their delivery in a timely manner, particularly those considered to be vulnerable, and this was found to be adequate. Medicines were handed to the people and were not posted through the letterbox. Patient returned medication was dealt with appropriately.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy uses appropriate equipment and facilities to provide its services. It keeps these clean and tidy. The pharmacy uses its equipment in a way that protects people's private information.

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 current information. The pharmacy's computer system was password protected. And information displayed on computer monitors was suitably protected from unauthorised view.

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 services provided by the pharmacy was available within the consultation room. Electrical equipment was visibly free of wear and tear and in good working order. PAT testing stickers were present and in date.

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.