General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Knights Headless Cross Pharmacy, 65 Evesham Road, Headless Cross, REDDITCH, Worcestershire, B97 4JX

Pharmacy reference: 1038874

Type of pharmacy: Community

Date of inspection: 31/05/2024

Pharmacy context

This is a community pharmacy in a residential area, opposite a GP surgery on the outskirts of Redditch, Worcestershire. The pharmacy dispenses NHS and private prescriptions. It sells a range of over-the-counter medicines. The pharmacy also offers seasonal flu and travel vaccinations, blood pressure testing as well as the Pharmacy First 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

Overall, the pharmacy suitably identifies and manages the risks associated with its services. Members of the pharmacy team monitor the safety of their services by recording their mistakes and learning from them. The pharmacy protects people's confidential information appropriately. Team members actively monitor the welfare of vulnerable people. And the pharmacy largely keeps the records it needs to by law.

Inspector's evidence

This was a well-managed pharmacy; day-to-day activities were observed to largely take place in accordance with the standards expected although some areas for improvement were identified. To help identify and manage risks associated with the pharmacy's services, the pharmacy was clean, and kept tidy, as well as organised. Team members processed and assembled prescriptions in different areas, the responsible pharmacist (RP) also worked and accuracy-checked prescriptions from a separate section in the dispensary. Staff processed prescriptions in batches to help limit clutter and rotated tasks. The RP described handling dispensing incidents which reached people in a suitable way, the relevant details were recorded and investigated appropriately. Errors that occurred during the dispensing process (near miss mistakes) were also routinely recorded. The details were collated and reviewed formally every month which helped identify any trends or patterns. Remedial activity was then undertaken to help minimise mistakes and discussions were held with the team to raise their awareness. Look-alike and sound-alike medicines were separated and highlighted, and warning labels had been placed in front of some stock as an additional alert.

Once prescriptions had been assembled, the RP usually conducted the final accuracy-check but the accuracy checking technician (ACT) who was also the pharmacy manager, could assist with this. When the ACT undertook this task, the RP clinically checked the prescription first. There was a standard operating procedure (SOP) in place to cover this process. However, the ACT was involved in other dispensing processes for these prescriptions. This carries risks.

The pharmacy had a range of documented SOPs to provide its team with guidance on how to complete tasks appropriately. There was evidence that staff had read and signed them. However, the odd SOP was missing (such as safeguarding, see below). Team members were clear on their roles and responsibility, and members of the pharmacy team knew what their tasks involved. The team knew which activities could take place in the absence of the RP. The correct notice to identify the pharmacist responsible for the pharmacy's activities was on display.

The pharmacy's team members had been trained to protect people's confidential information. The pharmacy displayed details on how it did this and the team ensured confidential information was protected. Confidential information was stored and disposed of appropriately. No sensitive details could be seen from the retail space. Staff used their own NHS smartcards to access electronic prescriptions and they had signed a declaration to ensure confidential information was protected. All staff including the pharmacist had been trained to safeguard the welfare of vulnerable people.

Team members could recognise signs of concerns; they knew who to refer to in the event of a concern and described concerns seen as well as how they had responded. This included offering the use of a

safe space, offering reassurance or comfort in certain situations, taking advice from the previous superintendent pharmacist, and documenting relevant details. Contact details for the local safeguarding agencies were easily accessible. However, there was no SOP available about this to provide guidance to the team.

The pharmacy had current professional indemnity and public liability insurance. A sample of registers seen for controlled drugs (CDs) and records of unlicensed medicines had been maintained in accordance with legal requirements. On randomly selecting CDs held in the cabinet, their quantities matched the stock balances recorded in the corresponding registers. Records of CDs that had been returned by people and destroyed at the pharmacy had also been suitably maintained. However, the odd gap was seen within the RP record. The nature of the emergency when a supply of a prescription-only medicine was made, in an emergency without a prescription was often missing. This could make it harder for the pharmacy to justify the supplies made and there were inaccurate or missing details about prescribers within the electronic private prescription register. This was discussed during the inspection.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough staff to manage its workload safely. Members of the pharmacy team are suitably qualified with a range of skills and experience. But the pharmacy delivers ongoing training in an unstructured way. This could affect how well they conduct tasks and adapt to change with new situations. And their performance has not been reviewed for some time. This could limit their ability to discuss feedback and concerns.

Inspector's evidence

The pharmacy team on the day of the inspection consisted of a locum RP, two trained dispensing assistants, the ACT, and an apprentice who were all full-time. There was also a regular pharmacist, a part-time medicines counter assistant and two delivery drivers. The pharmacy had an adequate number of staff to support the workload and the team was up to date with this. Staff wore uniforms and their certificates to verify qualifications obtained were on display. Contingency cover involved staff covering one another, they clearly worked well together as a team and were observed to be very capable in their respective roles.

Members of the pharmacy team asked relevant questions before selling medicines. They were aware of medicines which could be abused or had legal restrictions and sales of these medicines were monitored. Team members knew when to refer to the pharmacist appropriately. They were a small team, so communicated verbally. The apprentice was knowledgeable about the pharmacy's processes, protected study time was provided during quite periods. There were also opportunities to progress as one member of staff had been recently enrolled onto the NVQ3 in dispensing. However, there were no formal staff appraisals. And whilst some learning sessions for ongoing training were described as occurring through a few pharmacy support organisations, this was described as ad hoc training.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy's premises provide a suitable environment to deliver services from. The pharmacy is professionally presented. And people can have a conversation with a team member in a private area.

Inspector's evidence

The pharmacy’s premises were well presented, clean and clear of clutter. The pharmacy was bright with suitable ambient temperature for storing medicines and safe working. The premises were secure from unauthorised access. The retail area was large with a spacious, open plan dispensary behind although bench space was limited. There was still an adequate amount of space for staff to carry out dispensing tasks safely. There was also a separate consultation room to hold private conversations and provide services. The room was of an appropriate size, clearly signposted and accessible for people using wheelchairs and kept secure. Conversations at a normal level of volume could take place inside without being overheard.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides its services safely. Members of the pharmacy team help ensure that people with different needs can easily access the pharmacy's services. The pharmacy obtains its medicines from reputable sources, and it stores as well as manages them appropriately. Team members regularly identify people who receive higher-risk medicines and make the relevant checks. But they don't always record this information. This makes it difficult for them to show that people are provided with appropriate advice when these medicines are supplied.

Inspector's evidence

The pharmacy's services as well as its opening times were clearly advertised. A range of leaflets and posters were on display to provide information about various health matters. The area outside the medicines counter and leading up to it, consisted of clear, open space and wide sections. This helped people with restricted mobility to easily access the pharmacy's services. Team members explained that they served some people with diverse needs and made reasonable adjustments if this was required. This included providing people with written details or communicating verbally and physically assisting people who were visually impaired. Some of the staff were multilingual which assisted people whose first language was not English, or Google translate was used. There were also three seats available for people if they wanted to wait for their prescription(s).

The pharmacy provided local deliveries and the team kept records about this service. CDs and medicines requiring refrigeration were highlighted. Failed deliveries were brought back to the pharmacy, notes were left to inform people about the attempt made and no medicines were left unattended.

The pharmacy previously prepared medicines into multi-compartment compliance packs for many people onsite. This service had now moved to the company's hub. Once prepared at the hub, they were delivered to the pharmacy for collection or home delivery. The pharmacy ordered prescriptions on behalf of people for this service and specific records were kept for this purpose. Any queries were checked with the prescriber and the records were updated accordingly. Relevant details were processed through the pharmacy system, a file which included a copy of the prescription was then electronically sent to the hub before prescriptions could be processed there. Descriptions of the medicines inside the packs were provided. All medicines were removed from their packaging before being placed inside the compliance packs. However, patient information leaflets (PILs) were not routinely supplied. Staff explained that they were not provided by the company's hub. However, this is a legal requirement and could make it harder for people to have up-to-date information about how to take their medicines safely.

People could have their BP checked and their ambulatory BP could be monitored and checked over a 24-hour period through the pharmacy. The results were then sent to the GP surgery. Staff described noticing concerns, offering the service, and how this service had subsequently helped identify people with undiagnosed BP. This included situations which had resulted in the team calling an ambulance and people requiring hospital admission. The pharmacy provided the Advanced NHS service, Pharmacy First Service. The service specification and Patient Group Directions (PGDs) to authorise this were readily accessible and had been signed by the regular pharmacist. Suitable equipment was also present which

helped ensure that the service was provided safely and effectively (see Principle 5). Travel vaccinations were administered by the regular pharmacist on an appointment basis. Stock for this service was stored appropriately and the PGDs to authorise this service had also been signed by the regular pharmacist.

The workflow involved prescriptions being prepared in one area before the RP checked medicines for accuracy. The team used baskets to hold prescriptions and medicines during the dispensing process. This helped prevent any inadvertent transfer between them. The baskets were also colour coded which helped identify priority. After the staff had generated the dispensing labels, there was a facility on them which helped identify who had been involved in the dispensing process.

Staff were aware of the additional guidance when dispensing sodium valproate and the associated Pregnancy Prevention Programme (PPP). They ensured the relevant warning details on the packaging of these medicines were not covered when they placed the dispensing label on them and had identified people in the at-risk group who had been supplied this medicine. Team members also routinely identified people prescribed medicines which required ongoing monitoring and supplied relevant educational literature when required. Staff explained that they asked details about relevant parameters, such as blood test results for people prescribed these medicines. After obtaining this information however, there were no records kept about this.

The pharmacy used licensed wholesalers to obtain medicines and medical devices. Short-dated medicines were routinely identified. The team checked medicines for expiry and regularly kept records of when this had taken place. There were no date-expired medicines seen. Dispensed medicines requiring refrigeration and CDs were stored within clear bags. This helped to easily identify the contents upon hand-out. CDs were stored securely and the keys to the cabinet were maintained in a way which prevented unauthorised access. Medicines requiring refrigeration were stored in a suitable way and fridge temperatures were checked daily. Records verifying this and that the temperature had remained within the required range had been appropriately completed. Medicines returned for disposal, were accepted by staff, and stored within designated containers. People who brought sharps back for disposal were accepted provided they were inside sealed bins. Drug alerts were received electronically. Staff explained the action the pharmacy took in response and relevant records were kept verifying this.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the appropriate range of equipment and facilities it needs to provide its services safely. Its team members keep the equipment clean and use it in a way which helps keep people's confidential information safe.

Inspector's evidence

The pharmacy's equipment was mostly suitable and kept clean. This included standardised conical measures for liquid medicines, triangle tablet and capsule counters, a legally compliant CD cabinet, an appropriately operating pharmacy fridge, and access to current reference sources. Additional equipment for the pharmacy's services included an otoscope, tongue depressors, and a BP machine. The latter were new. However, there was also a tablet counting machine which had not been calibrated for some time. Computer terminals were password protected and their screens faced away from people using the pharmacy. This helped prevent unauthorised access. The pharmacy also had portable telephones which meant that conversations could take place in private if required.

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.