General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Grasmere Pharmacy, 1 Oakbank, Broadgate, Grasmere, AMBLESIDE, Cumbria, LA22 9TA

Pharmacy reference: 1086478

Type of pharmacy: Community

Date of inspection: 16/09/2019

Pharmacy context

This is a community pharmacy in the village of Grasmere, Cumbria. The pharmacy sells over-the-counter medicines and dispenses NHS prescriptions. It also dispenses private prescriptions. The pharmacy team offers advice to people about minor illnesses and long-term conditions. And it offers services including medicines use reviews (MURs) and the NHS New Medicines Service (NMS). It supplies medicines in multi-compartmental compliance packs 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 has suitable processes and written procedures to protect the safety and wellbeing of people who access its services. It mostly keeps the records it must by law. And it keeps people's private information secure. People can provide feedback about the pharmacy's services. And the pharmacy listens and makes changes to its services. The pharmacy team members have the skills and training to help safeguard the welfare of vulnerable adults and children. The pharmacists discuss and learn from errors they make while dispensing and from other common errors they learn about. They make changes to the way they work to reduce the risk of similar errors.

Inspector's evidence

The pharmacy was relatively small but had ample bench space in the dispensary. It had a small open plan retail area which led to the pharmacy counter. The pharmacy counter provided a barrier between the retail area and the dispensary. The pharmacist used a rear bench close to the pharmacy counter to do final checks on prescriptions, which helped him oversee sales of over-the-counter medicines and conversations between team members and people at the counter.

The pharmacy had a set of standard operating procedures (SOPs). And these were held in a ring binder. There was an index. And so, it was easy to find a specific SOP. The SOPs covered various processes including taking in prescriptions and dispensing. The team members were seen working in accordance with the SOPs. The previous pharmacy owner prepared the SOPs. The current pharmacy owner was in the process of reviewing each of the SOPs to ensure they were up-to date and reflected the current ways of working. Each team member had read the SOPs that were relevant to their role in the pharmacy. A team member said she would ask the pharmacist if there was a task they were unsure about. Or felt unable to deal with.

The pharmacy recorded any near miss errors that were spotted during dispensing. The details of the error were recorded in a near miss log. The pharmacy had a low dispensing volume and near miss errors were rare. The pharmacy did not employ any team members who dispensed. And so, the dispensing process was carried out entirely by the pharmacists. The pharmacist on duty explained that he often discussed common errors with the other pharmacists who worked at the pharmacy. They had discussed how to reduce the risk of mistakes happening. And had implemented several ideas. These included only stocking one strength of methotrexate, to stop different strengths being picked in error. The pharmacy had a process to record dispensing errors that had been given out to people. It recorded any incidents that happened and a copy of the report was kept in the pharmacy for future reference. The reports included the details of who was involved, what happened, why it happened, and what actions the pharmacy intended to do to prevent a similar error happening again. An example of a recent incident involved the pharmacy attaching an incorrect address label to a bag of medicines. To prevent a similar error happening again, the pharmacy introduced the use of baskets to hold individual prescriptions, labels and stock during the dispensing process.

The pharmacy advertised how the people who used the pharmacy could make comments, suggestions and complaints, via a notice in the retail area. The pharmacist was in the process of completing an annual patient satisfaction survey. People were asked to complete a short questionnaire about the service they had received from the pharmacy. And suggest ways the pharmacy could improve. The

pharmacy had recently started selling electronic cigarettes following several requests from people who used the pharmacy.

The pharmacy had up-to-date professional indemnity insurance. The responsible pharmacist notice displayed the name and registration number of the responsible pharmacist on duty. But it was in the consultation room. And so was difficult for people to see from the retail area. This is not in line with requirements. Entries in the responsible pharmacist record mostly complied with legal requirements. But the pharmacists did not record the time their duties ended each day. The pharmacy kept complete records of private prescription and emergency supplies. The pharmacy kept controlled drugs (CDs) registers. But they were not always completed fully, as some headers were missing. The pharmacy team checked the running balances against physical stock when new stock was delivered, or when stock was supplied to people. The running balances of three CDs in the registers were checked against the physical stock. One balance did not match. The importance of maintaining accurate running balances and undertaking regular balance checks was discussed with the pharmacist. The pharmacy kept complete records of CDs returned by people to the pharmacy.

The team held records containing personal identifiable information in areas of the pharmacy that only team members could access. Confidential waste was placed into a separate bin to avoid a mix up with general waste. The confidential waste was destroyed periodically using a shredder. The pharmacy did not outline to people using the pharmacy how it stored and protected their information. The team members understood the importance of keeping people's information secure. The pharmacy had submitted its latest data security and protection (DSP) toolkit.

The pharmacist on duty and the other regular pharmacists had completed training on the safeguarding of vulnerable adults and children up to level 2 via the Centre for Pharmacy Postgraduate Education. The team members gave several examples of symptoms that would raise their concerns. A counter assistant said she would discuss their concerns with the pharmacist on duty, at the earliest opportunity. A list of the key local safeguarding teams was available to the team.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has a small team with the appropriate skills to provide its services and manage its workload. The pharmacy supports its team members through their progress with training courses. It achieves this by providing them with a structured training programme and regular appraisals of their performance. The team members openly discuss how to improve ways of working. And they regularly talk together about how they can make improvements to the pharmacy's services. And they feel comfortable to raise professional concerns when necessary.

Inspector's evidence

At the time of the inspection, the team members present were the pharmacy's owner who worked two days a week as the responsible pharmacist, and a trainee counter assistant. A co-owner worked as the responsible pharmacist one day per week. The pharmacy's previous owner and a locum pharmacist covered the remaining days. The pharmacy also employed another trainee counter assistant. The pharmacist on duty supervised the counter assistant. And she was seen involving the pharmacist in offering advice to people who were purchasing over-the-counter products for various minor ailments. The pharmacist and counter assistant carried out their tasks and managed their workload in a competent manner. The counter assistant asked appropriate questions when selling medicines that could only be sold under the supervision of a pharmacist. And she was aware about the activities she could and could not do in the absence of a responsible pharmacist.

The pharmacy supported the trainee counter assistants with their training courses. It did this by providing them with protected training time during the working day. So, they could train without any distractions. The counter assistant said she was well supported by the pharmacy while working through her course and was close to completion. A plan was in place for her to enrol onto a dispensing course once she had completed the counter assistant course. The counter assistant said she received a lot of support from her colleagues and felt comfortable asking questions. The pharmacy had a structured appraisal process designed to support its team members. The appraisals were completed every nine months and were an opportunity for the team members to discuss what parts of their roles they felt they enjoyed and which parts they felt they wanted to improve. And discuss their personal development. The team members were then set objectives to help them achieve their goals.

The team did not have regular, formal meetings. But as it was a small team, the team members discussed topics such as company news, targets and patient safety, when the pharmacy was quiet. If a team member was not present during the discussions, they were updated the next time they attended for work. The team members openly and honestly discussed any mistakes they had made while dispensing and discussed how they could prevent the mistakes from happening again. And the team members felt comfortable to give feedback to the pharmacy's owners, to help improve the pharmacy's services. The pharmacist explained that the team had found it difficult to work with many different pharmacists which led to a lack of continuity. The pharmacist set up a WhatsApp group involving the team and the pharmacists. This allowed the team to improve their communication.

The team members said they were able to discuss any professional concerns with the pharmacist or the superintendent pharmacist. The team was not set any specific targets to achieve.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is secure and suitably maintained. It has a sound-proofed room where people can have private conversations with the pharmacy's team members.

Inspector's evidence

The pharmacy was generally clean and well maintained. The benches were spacious, clean and tidy. Floor spaces were clear with no trip hazards evident. There was a clean, well-maintained sink in the dispensary for medicines preparation and staff use. There was a WC available for staff use. And it was well maintained. The pharmacy had a sound-proofed consultation room which contained adequate seating facilities. The room was smart and professional in appearance. The room was signposted by a sign on the door. The temperature was comfortable throughout the inspection. Lighting was bright throughout the premises.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides an appropriate range of services, for the local and tourist community, to help people meet their health needs. The team members help people to safely take their high-risk medicines and they give them additional advice when it is necessary. They manage the risks associated with dispensing medicines in multi-compartmental compliance packs with suitable processes. The pharmacy sources and stores its medicines appropriately. And it completes checks on the expiry dates of its medicines. But it doesn't keep a record of when this has been completed. So, the team cannot effectively plan this task.

Inspector's evidence

The pharmacy had level access from the street to a push/pull entrance door. Large print labels were provided on request. The team members had access to the internet. Which they used to signpost people requiring a service that the team did not offer. The pharmacy advertised its services and opening hours in the retail area. Seating was provided for people waiting for prescriptions.

The team members regularly used various stickers during dispensing and they used these as an alert before they handed out medicines to people. For example, to highlight interactions between medicines or the presence of a fridge line or a controlled drug that needed handing out at the same time. The pharmacists were currently dispensing and completing the final check of medicines. The pharmacist ensured he took a mental break between the dispensing and checking processes and signed the dispensing label when each process was complete. And so, a robust audit trail of the process was in place. They used baskets to hold prescriptions and medicines. This helped the team members stop people’s prescriptions from getting mixed up. The team used marker pens to highlight the date of issue on the prescriptions of CDs that did not require safe custody. This system prevented the team members from handing out any CDs to people after the prescription had expired. The pharmacy did not always provide owing slips to people on occasions when the pharmacy could not supply the full quantity prescribed. And so, people were not given a record of the medicines they were outstanding. This could cause confusion to people, and resulted in an incomplete audit trail. The pharmacy offered a service to deliver medicines to people’s homes in exceptional circumstances. For example if the weather was particularly poor, or a person was housebound.

The pharmacy was in a tourist village. And so, the pharmacy often had requests from people for emergency supplies of their medicines. The pharmacy had a robust process to manage these types of requests. During the inspection, the pharmacist dealt with a request for an emergency supply of an inhaler for a person who had left their inhaler at home. The team members were seen asking the person several appropriate questions to make sure that an emergency supply was necessary. The pharmacist also accessed the person’s summary care records. He used the records to make sure he supplied the correct inhaler with the correct directions. The person expressed his thanks to the team and stated that it was an invaluable service.

The team members were aware of the risks associated with the supply of high-risk medicines. And they used alert stickers for warfarin, lithium and methotrexate to attach to bags which contained these medicines. The alert stickers were used to remind the team members to show the bag to the

pharmacist before it was handed to the person. The pharmacist often gave the person additional advice if there was a need to do so. But details of these conversations were not recorded on people's medication records. So, the pharmacy could not demonstrate how often these checks took place. The team members were aware about the requirements of the valproate pregnancy prevention programme. The team members had access to a support pack which contained warning stickers and information leaflets which could be given to people. The team had not completed a check to see if any of its regular patients were prescribed valproate and met the requirements of the programme.

The pharmacy supplied medicines in multi-compartmental compliance packs for people living in their own homes. And the pharmacy supplied the packs to people on either a weekly or monthly basis. The team members were responsible for ordering the person's prescription. And they did this around a week in advance. And then they cross-referenced the prescription with a master sheet to ensure it was accurate. The team members queried any discrepancies with the person's prescriber. The team members recorded details of any changes, such as dosage increases and decreases, on the master sheets. They dispensed the packs on a side bench which was out of the line of sight of the retail area. This was to make sure they weren't distracted while dispensing. The packs had dispensing labels attached. And the labels contained information to help people visually identify the medicines. The team routinely provided patient information leaflets with the packs.

Pharmacy only medicines were stored behind the pharmacy counter. The storage arrangement prevented people from self-selecting these medicines. The pharmacy had a date checking schedule to be completed every six months and it highlighted short-dated medicines. And removed them from the pharmacy shelves before they expired. But it did not keep a record of the process. And so, an audit trail was not in place. The team members could not confirm when the last check was completed. No out-of-date medicines were found following a random check. The team members recorded the date liquid medicines were opened on the pack. So, they could check they were in date and safe to supply. CD denaturing kits were available. The team members were not scanning products and undertaking manual checks of tamper evident seals on packs, as required under the Falsified Medicines Directive (FMD). But the pharmacy had the appropriate scanners and software to help them work in accordance FMD soon. The pharmacist expected the pharmacy to be compliant with FMD within the next six to twelve months.

Fridge temperatures were recorded daily using digital thermometers. A sample of the records were looked at. And the temperatures were found to be within the correct range. The pharmacy obtained medicines from several reputable sources. Drug alerts were received via email to the pharmacy and actioned. The pharmacy kept a record of what the action was. And so, a robust audit trail was in place that could be used in the event of a query.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy's equipment is clean and safe to use. And the pharmacy protects people's confidentiality.

Inspector's evidence

References sources were in place. And the team had access to the internet as an additional resource. The resources included hard copies of the British National Formulary (BNF) and the BNF for Children. The pharmacy used a range of CE quality marked measuring cylinders. Separate cylinders were used to dispense methadone. A separate tablet counter was used to dispense methotrexate and other cytotoxic medicines. The fridge used to store medicines was of an appropriate size. And the medicines inside were organised in an orderly manner. There was no evidence of electrical equipment having been subjected to portable appliance testing. But the equipment appeared to be in good working order and well maintained. Prescription medication waiting to be collected was stored in a way that prevented people's confidential information being seen by members of the public. And computer screens were positioned to ensure confidential information wasn't on view to the public. The computers were password protected. Cordless phones assisted the team in undertaking confidential conversations.

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.