General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: The Chemist Shop, 4 Rectory Lane, Glinton, PETERBOROUGH, Cambridgeshire, PE6 7LR

Pharmacy reference: 1087859

Type of pharmacy: Community

Date of inspection: 06/08/2019

Pharmacy context

This pharmacy is in the middle of the village, close to a satellite surgery. The pharmacy owner provides most of the pharmacist cover and all support staff are part-time. Its core activity is NHS dispensing. Most prescriptions dispensed are delivered to people. The pharmacy also offers Medicines Use Reviews (MURs) and New Medicine Service (NMS) consultations. It has a well-subscribed service supplying medicines in multi-compartment compliance packs to people who need help managing their medicines. And it also dispenses prescriptions for residents of some care homes. The pharmacist provides seasonal flu vaccinations under patient group directions (PGDs) and is planning to start a travel vaccination service soon.

Overall inspection outcome

Standards not all met

Required Action: Improvement Action Plan

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 not all met	1.6	Standard not met	The pharmacy does not have an accurate record of the responsible pharmacist.
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 not all met**

Summary findings

The pharmacy generally identifies and manages risks to protect people's safety. But it does not keep all the records it needs to by law, including the responsible pharmacist record. So, it may not always be able to show who the pharmacist in charge has been. However, its team members understand their roles and responsibilities and how to protect vulnerable people. They generally keep people's personal information safe. They seek people's feedback about the services they offer. And they learn from their mistakes. But they could do more to record the mistakes they correct during the dispensing process, so they can address any patterns or trends.

Inspector's evidence

The pharmacy had written standard operating procedures (SOPs) detailing how various tasks were to be completed. There was some evidence that staff had read most of these documents in the past but the audit trail on the signature pages wasn't always clear. The owner who was also acting as the responsible pharmacist (RP) explained that he had more recently obtained some new SOP templates and was due to replace the existing SOPs using these. The current SOPs covered the dispensing process, management of controlled drugs (CDs), RP regulations, dealing with dispensing incidents, date checking process, safeguarding children, confidentiality, and supply of higher-risk medicines including warfarin and methotrexate. Prescriptions for higher-risk medicines such as warfarin were highlighted so that the pharmacy could check that people were being monitored appropriately. But these checks weren't always recorded. And the RP could not remember if this was something the SOP recommended and said he would check this.

Dispensed prescription forms were held in a retrieval system so could be referred to when patients collected their medicines. The RP was aware of the information to provide to people about avoiding valproate during pregnancy and there were alert cards available to hand out with dispensed medicines. But there were no other leaflets or alert stickers available. The RP agreed to contact the supplier for more of these. Prescriptions for some CDs were highlighted to raise awareness of the 28-day expiry date of the prescription. The dispenser said that they didn't routinely highlight Schedule 4 CDs but would do so in future.

The RP could show how dispensing errors were recorded on the patient medication record (PMR) system. A recent entry was seen and included information about why and how the mistake had happened and what the pharmacy were doing to prevent a similar incident. There had been some improvement in recording near misses in the immediate weeks after the last inspection, but this had tailed off in recent months. But the dispenser said that the RP always told them about their mistakes and the team discussed risks in the dispensing process. They had clearly separated products with similar names and packaging and kept higher-risk medicines away from other items to reduce picking errors.

Staff were able to explain the tasks that required a RP to be present. They were observed following the correct procedure over lunchtime when there was no RP at the premises. They knew that some medicines could be abused and could explain the legal limits on sales of pseudoephedrine products and analgesics.

There was evidence of a patient survey currently being undertaken. Results of the community pharmacy patient survey completed for the past year were displayed on the NHS website. Respondents to the survey were very positive about the pharmacy and the level of customer service it provided. The RP also gave examples of positive feedback he had received about the level of service the pharmacy provided, making urgent deliveries after work when needed and making his contact details available so he could provide pharmacy services over public holidays in emergency situations. A poster highlighting the pharmacy complaints process was displayed in the shop. The dispenser could explain how to deal with a complaint and said any issues were referred to the RP. Most recent complaints had been about stock supply issues which were outside of the control of the pharmacy. They tried to liaise with prescribers for alternatives where possible.

A certificate evidencing the professional indemnity and public liability insurance in place was displayed. The pharmacist had displayed the correct RP notice. The RP record was kept electronically but the records were not complete. There were several dates during July with no record of who the RP had been. And the RP did not always sign-out of the record at the end of their shift. This had been raised during a previous inspection and had not improved. Private prescriptions and emergency supplies were now recorded electronically. There were records available to view. However, some of the entries did not include all the required information. For example, some of the details recorded about the prescribers were inaccurate or missing. And some of the emergency supply records did not include the nature of the emergency. This could make it harder for the pharmacy to demonstrate why they had made a supply without a prescription if there was a future query. Controlled drug registers were available and were largely complete. Running balances were kept. There were a few missing headers in each of the registers checked. There was a designated book to record patient-returned CDs.

Prescriptions and patient medication records could not be viewed by the public and were kept in the dispensary. Confidential waste was collected in baskets and then shredded on site. Dispensing activities were shielded from public view. Staff were aware of their obligations to protect patient confidentiality and there were some procedures relating to this. The pharmacist was using his own NHS smartcard to access electronic prescriptions. But other staff did not have their own cards and were using the card belonging to the pharmacist. This could mean that the audit trail created when accessing the NHS spine does not always accurately reflect those involved.

The pharmacist had completed level 2 safeguarding training and there was a written procedure referring to safeguarding children but not one for vulnerable adults. The pharmacy's chaperone policy was displayed at the entrance to the consultation room. Staff had not received any formal training about safeguarding but said they would refer any concerns to the pharmacist if they arose. The delivery driver explained how he had reported back concerns about vulnerable patients who hadn't taken receipt of prescription deliveries. The dispenser also described how the pharmacy had reported concerns to a GP about a person who was not taking their medicines as prescribed. The person was receiving closer support because of this.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy team members work closely together, and they can suggest improvements to make services better for people. The staff have completed or are undertaking the required accredited training for their roles. But they don't always get chance to do training during working hours. So, it is harder for them to finish this training and to keep their skills and knowledge up to date.

Inspector's evidence

The pharmacy team comprised a trained NVQ level 3 dispenser, a trainee dispenser, a trainee medicine counter assistant, and two delivery drivers. All staff worked part-time but increased their hours to cover holidays or busier periods when needed. The owner provided most of the pharmacist cover. It was relatively quiet during the inspection and the team could manage the workload.

The trainee dispenser and trainee medicines counter assistant were taking longer than usual to complete their training. There was little provision during working hours to complete training, but the RP said he had recently agreed with the trainee dispenser for them to do extra time to try to get their course completed. The course provider had been made aware of delays in the training and was said to have agreed to extend the training time. There were no formal reviews for staff, but staff said they were given regular feedback about how they were working.

The RP provided evidence of the training he had completed to be able to provide vaccination services safely. This included vaccination techniques, dealing with anaphylaxis, basic life support, and safeguarding.

This was a very small team and they all worked closely together. The trainee dispenser was observed referring queries to the pharmacist when needed. Staff said they had occasional staff meetings and felt able to raise any concerns or make suggestions about how to improve the pharmacy. One proposal was to create a better system of recording handover information about the care homes and compliance packs service so that messages weren't missed. The RP said he was happy to adopt this change. The staff also said they were briefed on pharmacy-related topics by the RP from time to time.

There were no targets set for services.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy's premises are adequate for the services it provides. The pharmacy team could improve some of its housekeeping routines to make sure all areas of the pharmacy are kept suitably clean.

Inspector's evidence

The premises were small for the volume of work undertaken. The RP explained they now owned the premises rather than leased and had started to consider options to expand but these plans were at a very early stage.

The pharmacy was generally clean and tidy with no slip or trip hazards but the sink in the dispensary needed a thorough clean. There was a separate sink for handwashing. Hot and cold running water was available. There was adequate lighting and ventilation throughout and the room temperature was comfortable during the inspection and suitable for storing medicines. There was a seat available in the shop for waiting customers. There was a small step up into the pharmacy, making it difficult for people with wheelchairs or prams to get into the premises. The RP explained he had been in contact with the local council and was trying to get the pavement altered to create level access.

The dispensary was clearly separated from the retail area and pharmacy-only medicines were stored behind the medicines counter. There was just about enough storage and dispensing space for the activities undertaken. The dispensing benches had several stacks of baskets containing prescriptions waiting to be checked as this was the only place available to keep these. This meant there was limited space in the main dispensary for dispensing. But there was additional dispensing space in a room off the dispensary where compliance packs were assembled. This room was also used as a consultation room to have private conversations with people when needed. Personal information was said to be removed from view when this happened. The entry to this room was not wheelchair accessible.

There were maintenance contracts in place for IT, alarm systems, and waste management. The pharmacy could be secured to prevent unauthorised access.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy offers a limited range of services, but it generally provides these in a safe manner. Its delivery drivers know their customers well and they report any concerns they have about the people they deliver to. The dispensers organise the compliance pack service well. And the pharmacy gets its medicines from reliable sources and stores them carefully to reduce the risk of mistakes. But the pharmacy could do more to make sure all medicines that have reached their expiry date are removed from display.

Inspector's evidence

Opening hours were displayed at the entrance to the pharmacy. A small range of health-related leaflets were available including a double-sided leaflet detailing some of the pharmacy services. There was no other practice leaflet on display, so people may not be fully aware of all the services the pharmacy provides.

Some people were supplied their medicines in multi-compartment compliance packs where they needed this level of support. For supplies made to care homes and for people living in their own homes, enough time was allocated to order and receive prescriptions and then dispense the medication so that continuity of care was not jeopardised. Both dispensers were involved in this activity. Unexpected changes or missing prescription items were queried. Packs were dispensed away from the main dispensary to reduce the risk of distraction however space for this was limited. The workload was arranged across four weeks to be manageable. Descriptions were added to trays for people living at home. Package information leaflets were not usually provided beyond the first supply. The dispenser said that people often did not want these but agreed to make sure leaflets were supplied routinely in future.

Most of the prescriptions dispensed were delivered to people. Records were kept which showed which prescriptions had been delivered successfully or if they had been brought back to the pharmacy undelivered. Some prescription deliveries were signed for by recipients though the driver often signed on behalf of people if they found it difficult to sign themselves. The driver clearly knew those people he delivered to regularly and their circumstances. Priority was given to delivering fridge lines first especially during warmer weather.

Pharmacy-only medicines were stored behind the counter to ensure appropriate advice and supervision could be provided when sold. Medicines requiring refrigeration were kept in the pharmacy fridge and the maximum and minimum temperatures were generally checked and recorded daily. The records viewed were in the required range.

Medicines were obtained from licensed wholesalers and specials suppliers, and invoices from these sources were observed. Some date checks were recorded and there were no out-of-date items found amongst dispensing stock. However, two date-expired medicines were found in the shop. And some liquid oral medicines were not marked with the date of opening where this affected the shelf-life of the product. These were all removed from stock during the visit. There was evidence that the pharmacy received drug recall notices and safety alerts via email. But it didn’t always keep a record of what it had

done about these. This could make it harder for the pharmacy to show it has taken appropriate action if there was a future query.

The pharmacy had obtained the right equipment and had paid for the software needed to comply with the Falsified Medicines Directive (FMD) but needed a code to start using it. Staff training needs had also been considered and there were plans to provide this training once the system was ready to use.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide its services safely.

Inspector's evidence

The pharmacy had a range of reference sources in hard copy and online. They also had access to information and advice from their insurers if needed to help with professional checks.

Patient records were stored electronically. Screens could not be viewed by the public. A range of crown stamped measures were available which were clean. One was reserved for measuring methadone. The counting triangle was clean. The pharmacy had cordless phones and staff could move to quieter areas to hold phone conversations out of earshot of other customers.

All electrical equipment appeared to be in good working order and was tested regularly. The blood pressure meter in use was less than one year old and the dispenser said it was changed regularly.

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.