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: 19/02/2020

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 and most of the prescriptions it dispenses 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 has started a travel vaccination service in recent months.

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

Overall, the pharmacy identifies and manages risks to protect people's safety. Its team members understand their roles and responsibilities. They generally keep people's personal information safe. They seek people's feedback about the services they offer. And they try to learn from their mistakes to improve their services. The pharmacy largely keeps the records it needs to by law. But some records are not complete, and others are not easy to read. This may make it harder to rely on these records in the event of a future query.

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) at the time of the inspection, had already 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 some higher-risk medicines.

Staff were able to explain the tasks that required a RP to be present. They knew that some medicines could be abused and could explain the legal limits on sales of pseudoephedrine products and analgesics. There was an audit trail on dispensed medicines showing who had dispensed and accuracy-checked each item. In most cases, prescriptions were dispensed by dispensers and the RP then checked them. Occasionally, the RP had to self-check items he had dispensed. He understood that taking a mental break between dispensing and checking stages helped to reduce the risk of errors.

Dispensed prescription forms were held in a retrieval system so could be referred to when people came to the pharmacy to collect 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. There were also leaflets and alert stickers available. However, the pharmacy didn't currently have any patients who were in the at-risk group. Prescriptions for some CDs were highlighted to raise awareness of the 28-day expiry date of the prescription. The RP said that he didn't routinely highlight Schedule 4 CDs. This could increase the chances of some prescriptions being given out when the prescription was no longer valid. The RP understood the checks to make when supplying other higher-risk medicines such as warfarin or methotrexate. These checks included asking about people about possible side-effects, making sure the person knew what does they were taking, and seeing if the person was having regular blood tests. However, prescriptions for these medicines weren't always highlighted. And interventions were not always recorded. This made it harder for the pharmacy to demonstrate that people were getting the information they needed when these medicines were supplied.

The RP could show how dispensing errors were recorded on the patient medication record (PMR) system. An 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 was some evidence that near

misses were recorded each month. But the records didn't give much information about why mistakes may have happened and what was being done to reduce similar events in future. This could make it harder to spot any patterns or trends or check that any improvements were working. 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.

Results of the community pharmacy patient survey completed across 2019 and 2020 were displayed in the pharmacy's front window. Respondents to the survey were very positive about the pharmacy and the level of customer service it provided. A poster highlighting the pharmacy complaints process was displayed in the shop though this was a little tatty. The trainee dispenser could explain how to deal with a complaint and said any issues were referred to the RP.

A certificate evidencing the professional indemnity and public liability insurance in place was available. The pharmacist had displayed the correct RP notice. The RP record was now kept in hard copy and the records were complete though not always clearly legible. The RP said he would make sure the records could be more easily read in future. Private prescriptions and emergency supplies were now recorded electronically. There were records available to view. However, some of the entries had not been made correctly on the PMR so were not transferred into the electronic register. For example, some of the prescriptions had been entered as NHS prescriptions. Also, some of the prescribers' details were inaccurate or missing. This could make it harder for the pharmacy to locate information in the event of a future query.The RP said he would review the way that these prescriptions were entered in future to make sure all entries were completed correctly. Controlled drug registers were available and those checked were complete. Running balances were kept. 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 RP 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 RP. This could mean that the audit trail created when accessing the NHS spine does not always accurately reflect those involved.

The RP had completed level 2 safeguarding training; he was due to complete refresher training about this. 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.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has just about enough staff to manage its workload safely. Its staff have completed or are undertaking the required accredited training for their roles. They work closely together with each other and with the pharmacist, and they understand their roles well. However, the lack of a formal approach to ongoing training may make it harder for the pharmacy's staff 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 one delivery driver. Since the previous visit, a delivery driver had left; the other pharmacy staff were picking up the additional deliveries. All staff worked part-time but increased their hours to cover holidays or busier periods when needed. The owner provided most of the responsible pharmacist cover. Very few people visited the pharmacy during the inspection as most of the prescriptions were delivered to people at home.

Due to the length of time a previous training course had been taking to complete, the trainee dispenser had had to start a new dispensing assistant's course. This new course needed modules to be completed and submitted online. The RP said he had agreed with the member of staff for them to get at least half an hour each week to do training at work. The trained dispenser had recently attended a training course about providing support to people to stop smoking. The RP was able to provide evidence of the practical and theory-based training he had completed to be able to provide the vaccination services offered under patient group directions (PGDs). This training included administration technique.

This was a very small team and they all worked closely together. The trainee dispenser was observed referring queries to the RP 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. The staff also said they were briefed on pharmacy-related topics by the RP from time to time. There was a clear sense that the team considered themselves part of the local community and they described how they tried to look after people's welfare, especially more vulnerable people. This had extended to giving people a lift back home if needed and dealing sensitively with people suffering from dementia.

There were no formal reviews for staff, and apart from the training described above, there was no structured approach to ongoing training. However, staff said they were given regular feedback about how they were working.There were no targets set for services.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy's premises are very small compared to the dispensing workload, but they are adequate for the services it provides. It has shown some improvement in its cleaning routines since the last inspection. But it could still do more to make sure all areas of the pharmacy are kept suitably clean and tidy.

Inspector's evidence

The premises were small for the volume of work undertaken. The RP showed the inspector plans for extending the premises to increase private areas for consultations, storage and dispensing space. He recognised that the current space was too small. There was no indication at the time of the visit about when the changes to the premises were likely to happen.

The pharmacy was fitted out to a basic standard. Flooring was very worn throughout but there were no trip hazards. The dispensary was clearly separated from the retail area and Pharmacy (P) 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 in the room was said to be removed from view when this happened. The layout of the premises meant that this room was not wheelchair accessible.

Dispensing benches and the consultation room were generally clean though cluttered due to lack of space. Some of the shelves were rather dusty and the floor in storage areas was not clean in places. There were adequate handwashing facilities and a separate sink for reconstituting medicines. 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. The pharmacy had maintenance contracts in place for IT, alarm systems, and waste management. And it could be secured to prevent unauthorised access.

Principle 4 - Services ✔ Standards met

Summary findings

Overall, the pharmacy provides its services in a safe manner. It considers the overall workload when deciding when it is safe to provide additional services such as travel vaccinations. Its team members know their customers well. The pharmacy gets its medicines from reliable sources. And it generally stores them appropriately to reduce the risk of mistakes.

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, generally enough time was allocated to order and receive prescriptions and then dispense the medication so that continuity of care was not jeopardised. However, the pharmacy did not always receive a prescription for one item in time for a person receiving weekly multi-compartment compliance packs. This meant that the pharmacy sometimes had to supply one day's worth of that medicine in advance of receiving a prescription, as an emergency supply. The dispenser acknowledged that he could order the prescription a little earlier in future and this would resolve the issue. He said he would do this in future. 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 provided. One care home was reluctant to receive these leaflets each time. The dispenser understood that the pharmacy was obliged to provide them.

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 signed on behalf of some people if they found it difficult to sign themselves.

Pharmacy 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.

The RP provided a range of vaccinations under both private and NHS PGDs. He had evidence of completing the appropriate training to provide these services safely. Travel vaccinations were referred through CityDoc using an online booking process for appointments. The RP had considered how these services could impact on other pharmacy activities. To manage the workload safely, he had excluded appointment times at certain times of the week when dispensing activity was greatest. As he was the only person providing the service, he had also excluded appointment times when he was absent.

Medicines were obtained from licensed wholesalers and specials suppliers, and invoices from these sources were observed. Date checks were recorded and the last checked had been completed in October 2019. There were no out-of-date items found amongst dispensing stock. However, some liquid oral medicines were not marked with the date of opening where this affected the shelf-life of the product. Those found were 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 routinely 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 software needed to comply with the Falsified Medicines Directive (FMD) but were awaiting training from the supplier to start using it.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide its services. The pharmacist makes sure he has the right equipment and emergency medicines to hand to provide travel vaccinations safely.

Inspector's evidence

The pharmacy had a range of reference sources in hard copy and online. It also had access to information and advice from its insurers if needed to help with professional checks. A range of crown-stamped measures were available which were clean. One was reserved for measuring controlled drugs to prevent the risk of cross-contamination. Other counting equipment 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. The RP kept the equipment he needed for the travel vaccination service readily to hand, including adrenaline autoinjectors. This meant he could react quickly if a person suffered an anaphylactic reaction to a vaccination. There were also suitable facilities for disposing of sharps waste safely.

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.