General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Mr Pickford's Express Pharmacy, 8 Spencer Court, CORBY, Northamptonshire, NN17 1NU

Pharmacy reference: 1099383

Type of pharmacy: Community

Date of inspection: 25/11/2021

Pharmacy context

This is a community pharmacy situated in the main shopping centre in Corby. Most of its activity is dispensing NHS prescriptions and giving advice about medicines over the counter. The pharmacy supplies medicines in multi-compartment compliance packs to people who live in their own home. Other services that the pharmacy provides include flu vaccinations, as both an NHS and private service, and substance misuse services. The pharmacy also delivers medicines to people's homes. The pharmacy was also providing the Covid-19 vaccination service from an associated premises. This inspection was undertaken during the Covid-19 pandemic.

Overall inspection outcome

✔ **Standards 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 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 adequately manages the risks associated with the provision of its services. Its team members have defined roles and accountabilities. The pharmacy manages people's personal information safely. The pharmacy mainly has adequate procedures to learn from its mistakes. But it doesn't always record all of its mistakes so it could be missing opportunities to learn from them. And team members do not always adhere to the pharmacy's standard operating procedures for assembling and supplying medicines, including the substance misuse service. This could increase the chance of mistakes not being detected before medicines are supplied to people.

Inspector's evidence

The pharmacy had a set of up-to-date standard operating procedures (SOPs). They had been read by the pharmacy team who mainly followed them. But the SOP relating to dispensing medicines said that the 'dispensed by' and 'checked by' boxes on the dispensing labels should be initialled. And this was not always done for medicines provided as part of the substance misuse service. Some of these medicines had been put in an area set aside for collection before they had been clinically or accuracy checked by the pharmacist. The dispenser said the medicines had been put there by mistake and said that from now on would initial the dispensed by box on the medicine label.

The counter assistant had recently started at the pharmacy and knew when she could sell a medicine safely and when she needed to seek advice or support from another member of the team. She was aware that prescriptions had a six-month validity from the date on the prescription apart from controlled drugs (CDs) which had a 28-day validity. Prescriptions waiting collection that contained a CD were highlighted as a reminder to staff.

The pharmacy had a process for recording dispensing mistakes that were identified before reaching a person (near misses) and dispensing mistakes where they had reached the person (errors). Near misses were discussed with the member of staff at the time and the aim was to record them in a near miss log. When the log was checked there were some gaps in time between the entries and the pharmacist accepted that not all near misses had been recorded. The pharmacist aimed to review the near miss log monthly but had not had the opportunity to do this for the last couple of months. Reviews were discussed with the team but a record of this wasn't made.

The pharmacy adequately maintained appropriate legal records to support the safe delivery of its services. CDs people had returned had recently been destroyed and were recorded in accordance with requirements. Dispensed CDs waiting collection in the CD cupboard were clearly separated and the corresponding prescriptions were in date. CDs were audited regularly but a check of a random CD showed that the running balance in the register and the quantity in the CD cupboard didn't match; a second running balance check did match. The pharmacist subsequently advised the inspector that an entry had been missed in the register. The pharmacy displayed who the responsible pharmacist (RP) in charge of the pharmacy was. The RP record showed who the RP in charge of the pharmacy had been.

The pharmacy had appropriate professional indemnity insurance. There was a complaint procedure in place. Computer terminals were positioned so that they couldn't be seen by people visiting the pharmacy. Access to the patient medication record was password protected. Confidential paperwork

was stored securely. Confidential waste was destroyed safely. The pharmacist was aware of safeguarding requirements.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy’s team members work well together and adequately manage the workload within the pharmacy. They are suitably trained for the roles they undertake. Team members can raise concerns if needed.

Inspector's evidence

During the inspection the pharmacy team adequately managed the day-to-day workload. There was one pharmacist, three appropriately trained members of staff and one in training. Staff said they felt supported by the pharmacist and one was hoping to start the pharmacy technician course. Staff said they could raise concerns if necessary. Team members had ongoing informal training from the pharmacist to keep their skills and knowledge up to date.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy keeps its premises safe, secure and appropriately maintained. The pharmacy makes changes to help keep staff and people using the pharmacy safe during the pandemic.

Inspector's evidence

The pharmacy was maintained to a suitable standard. The pharmacy had an automatic door providing easy access for people with a disability or with a push chair. The pharmacy had an air conditioning system to maintain a suitable temperature; there was adequate lighting and hot and cold running water was available. The dispensary was a suitable size for the services provided. There was a separate room upstairs area for assembling and managing multi-compartment compliance packs which was also adequate.

The pharmacy had appropriate processes in place to support safe working during the Covid-19 pandemic. The pharmacy had a sign on the door which restricted access into the pharmacy. There were markers on the floor, so people knew where to stand while waiting in the public area. There was plastic screening at the pharmacy counter to provide re-assurance to both the staff and the customers. There was hand sanitiser available. The pharmacy was cleaned daily. The pharmacy team were having regular Covid-19 lateral flow tests which they reported to NHS England. Unauthorised access to the pharmacy was prevented during working hours and when closed.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy has changed the way it provides services during the Covid-19 pandemic to keep its staff and the people who use its services safe. And the pharmacy gets its medicines and medical devices from reputable sources. It mainly stores them safely and it takes the right actions if medicines or devices are not safe to use to protect people's health and wellbeing. The pharmacy does not routinely highlight prescriptions for higher-risk medicines. This could make it harder for staff to identify these prescriptions and provide the information people need to take these medicines safely. The pharmacy offers healthcare services which are mainly adequately managed and are accessible to people. But the pharmacy needs to make sure that it always follows the procedures in place to ensure that dispensed medicines go through appropriate checks before being supplied.

Inspector's evidence

The pharmacy team understood the signposting process and used local knowledge to direct people to local health services. The pharmacist knew the advice about pregnancy prevention that should be given to people in the at-risk group who took sodium valproate. The pharmacist gave a range of advice to people. Examples he gave included advice about changes in dose and new medicines. He highlighted a recent intervention for a person who had started rivaroxaban. He also gave advice to people taking higher-risk medicines such as warfarin, lithium, and methotrexate. But prescriptions for these medicines were not routinely highlighted which could make it harder for staff to identify these prescriptions and provide people with up-to-date information about the medicines they were taking. The pharmacist said he would review the process.

The pharmacy used baskets during the dispensing process to keep medicines and prescriptions separated to reduce the risk of a mistake being made. The pharmacy mainly used a dispensing audit trail which included use of 'dispensed by' and 'checked by boxes' on the medicine label. This helped identify who had completed each task. However, when medicines for the substance misuse service were checked some had only one initial across both boxes and others had none. The medicines with a single initial had been dispensed the previous day and had only been signed by the pharmacist, not by the team member who dispensed it. This meant it might be more difficult to discuss a mistake with the person who made it if one occurred. Several other medicines for the substance misuse service were in bags waiting to be supplied. The dispenser had dispensed the medicine on the day of the inspection. For one of these medicines there had been a change of quantity on the prescription, but the dispenser had failed to initial the 'dispensed by' box or give it to the pharmacist to accuracy check and carry out a clinical check. This meant that a medicine might have been supplied to a patient without a review by a pharmacist. The dispenser said that he had made a mistake and had put the medicines away in a hurry because of the inspection. None of the medicines had been supplied. He said that this wasn't the usual process. The procedure was to get a clinical and accuracy check by the pharmacist before the medicine was supplied.

The pharmacy used a dispensing hub based in another pharmacy of the same company to dispense some of their original pack prescriptions and most of the medicines supplied in a multi-compartment compliance pack. The dispenser was able to clearly explain how this process worked to ensure that the medicines were supplied safely and in a timely manner. The compliance packs seen had the colour and

shape of medicines recorded to make them easily identifiable. But the packs didn't have patient information leaflets. The dispenser said she would raise this with the hub. The pharmacy delivered medicines to some people. The person delivering the prescription maintained appropriate distance due to the pandemic.

The pharmacy was no longer using the pharmacy robot which meant that the space for storing medicines was a little small. Some of the drawers were a little untidy. Some original containers had cut blisters from other packs and other brands. This increased the risk of out-of-date or recalled medicines being supplied. The pharmacist said he would stop this process. Most bottles of liquids had the dates that they had been opened recorded. But some bottles were seen that had a shorter expiry date once opened that didn't have the opening date recorded. The pharmacist said that he would remind staff to record the date when opening a bottle. Date checking was carried out regularly; there were records available. A sample of medicines checked were in date.

Records showed that medicines that required refrigeration were stored within the required range of 2 and 8 degrees Celsius. The maximum temperature shown on the fridge at the time of the inspection was 13 degrees Celsius; the pharmacist explained that the fridge had been open longer than usual that morning and that might have been the cause. The pharmacy only used recognised wholesalers to supply them with medicines. The pharmacy had a procedure for managing drug alerts.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has access to the appropriate equipment and facilities to provide the services it offers safely.

Inspector's evidence

The pharmacy used suitable measures for measuring liquids. It had up-to-date reference sources. CDs were stored securely. The pharmacy had two fridges. Records showed that the pharmacy hadn't had a recent portable electrical equipment safety test. The pharmacist said he would speak to head office to arrange one. Equipment looked in a reasonable condition. CDs were stored appropriately.

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.