General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Cornwell's Chemists, 51-53 Bodmin Avenue, Weeping Cross, STAFFORD, Staffordshire, ST17 0EF

Pharmacy reference: 1105665

Type of pharmacy: Community

Date of inspection: 08/04/2024

Pharmacy context

This busy community pharmacy is located alongside shops and local services in the Weeping Cross area of Stafford. The pharmacy dispenses NHS prescriptions, and it provides NHS funded services such as the Pharmacy First service, blood pressure testing and seasonal vaccinations. The pharmacy team dispenses some medicines into multi-compartment compliance packs for people to help make sure they remember to take them and supplies medicines to a care home. Private services are also available, and these include travel vaccinations and ear wax removal.

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	1.1	Standard not met	The pharmacy team had not read the latest pharmacy procedures (SOPs). Several of the pharmacy processes had changed considerably when the new computer system was installed, so the team may not have been following the correct procedures.
		1.2	Standard not met	The impact of the new PMR system has been inadequately monitored and reviewed. This has meant that issues with staff training and effect that the system has had on the pharmacy's processes have not been identified and addressed promptly.
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 not all met	4.2	Standard not met	The safety and efficiency of the pharmacy's services have been negatively impacted by the new PMR system. The quality of the service provided to the care home is hindered by the implementation of the new PMR system and the working relationship between the care home, the pharmacy and the surgery.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance **Standards not all met**

Summary findings

Changes to the way that the pharmacy team are expected to work are not implemented effectively. Members of the pharmacy team have not read the current written procedures, so it is unclear whether they are working in the right way. Ongoing monitoring of the risks associated with system changes is not effective. And additional training needs or problems are not promptly identified and addressed. Pharmacy team members discuss their mistakes so that they can learn from them. And they understand their role in protecting vulnerable people and they keep people's personal information safe.

Inspector's evidence

The pharmacy was part of a small chain of pharmacies located in Staffordshire and Stoke-on-Trent. A new patient medication record (PMR) system had been installed at the pharmacy a month prior to the inspection and the new system required the pharmacy team to process prescriptions in a different way to the previous system that was in place. The pharmacy team explained that they felt that the training on how to use the new system had not been particularly thorough, and some members of the team had been absent for the training session and had learnt how to use the system from their colleagues. The team gave examples of some of the issues that they had identified. For example, processing certain prescriptions for the care home, being limited by the number of computer terminals that were available, and processing prescriptions from before the new system was installed. Some of these issues had been raised with head office, and some had not. The team did not appear aware of any IT support for the new PMR, or whether there were any company experts that they could contact for help.

A range of corporate standard operating procedures (SOPs) had been produced by the superintendent pharmacist (SI) to reflect the new computer system. But the responsible pharmacist (RP) and pharmacy team were unaware of these and therefore had not read them. This meant that the team may not have been working in accordance with the procedures expected by the superintendent pharmacist (SI) and some of the questions about the new PMR may have been answered if the pharmacy team had read the updated SOPs in preparation for its installation. A link to the previous SOPs had been saved to the computer in the office and this link had been deleted when new computer hardware had been installed for the new PMR. The pharmacy manager was on holiday but was contacted and provided a dispenser with instructions on how to access the previous SOPs so that she could demonstrate the training logs had been completed last year. The pharmacy's dispensing procedures had changed considerably since those SOPs had been issued so the pharmacy team needed to read the new ones to ensure their working practices reflected the changes.

The dispensing process had been designed using the in-built safety measures and workflow efficiency tool that the PMR system provided. Each member of the team had an individual log-in for the PMR system which provided an audit trail of who had been involved with the dispensing process. Every prescription was clinically checked by a pharmacist before it was released for dispensing. The Management information was available on the new computer system which showed the percentage of products scanned and the number of incorrect barcodes scanned. These checks showed whether the pharmacy team members were complying with the process and their dispensing accuracy.

The pharmacy team gave examples of where medicines with similar names had been separated and the

dispensary shelves had been labelled to reduce the chances of them being selected in error. These were labelled with brightly coloured stickers to provide a visual alert to the dispensers. Brightly coloured stickers were also used to highlight where there was chance of selecting the incorrect pack size. The team gave examples of how the new computer system had inbuilt patient safety features and, if it is used correctly, should reduce the risk of picking errors due to the barcode of each medicine being scanned to ensure it matched the medicine prescribed.

The pharmacy team members had a clear understanding of the complaints process. People could give feedback to the pharmacy team in several different ways; verbal, written and via email. The pharmacy team tried to resolve issues that were within their control and would involve the RP or pharmacy manager if they could not reach a solution and would contact head office for further support. The pharmacy team were aware of some complaints that had been made by the management of the care home about various issues, and they had reviewed their service to try and reduce the chances of similar issues occurring in the future. Issues with communication between the care home, the surgery and the pharmacy appeared to be an ongoing issue that the pharmacy team said they had tried to resolve, however it continued to be a cause of frustration.

Members of the pharmacy team were knowledgeable about their roles and discussed these during the inspection. Team members were trained to deliver some of the pharmacy's private services, such as ear wax removal, to allow the pharmacist to do other tasks. A dispensing assistant correctly answered hypothetical questions related to high-risk medicine sales and discussed how she managed requests for codeine containing medicines.

The pharmacy had up-to-date professional indemnity insurance. The Responsible Pharmacist (RP) notice was clearly displayed, and the RP log met requirements. Controlled drug (CD) registers were in order. Patient returned CDs were recorded in a register. Private prescription records were seen to comply with requirements. Specials records were maintained with an audit trail from source to supply. Home delivery records were maintained electronically.

Confidential waste was stored separately from general waste and sent offsite to be destroyed securely. The pharmacy team members had their own NHS Smartcards and they confirmed that passcodes were not shared. The pharmacy team had completed training on safeguarding as part of the NHS Pharmacy Quality Scheme (PQS) and the RP had completed level three safeguarding training. The pharmacy team understood what safeguarding meant and a list of safeguarding contacts was displayed in the dispensary. The dispensing assistants gave examples of types of concerns that they may come across and correctly described what action they would take.

Principle 2 - Staffing ✔ Standards met

Summary findings

There are not enough suitably trained team members available to support the safe and effective delivery of pharmacy services. Pharmacy team members are struggling to keep up with dispensing tasks and some less urgent tasks are not being done. The team work well together, and they can raise concerns and make suggestions.

Inspector's evidence

The pharmacy team comprised of a regular pharmacist, a pharmacy manager (pharmacy technician), two dispensing assistants, and three trainee dispensing assistants. In addition, a trainee pharmacy technician based at a hospital pharmacy worked two days each week as part of a cross-sector training programme. Home delivery services were provided for limited hours each week and the drivers were based at another pharmacy. A trainee dispensing assistant had worked at the pharmacy for approximately 6-months and whilst she was aware that she had been enrolled onto an accredited training course she had not started it and had not received instructions on how to access the course materials.

The team had a clear understanding of the tasks that they had been allocated for the day. They used a rota system so that they knew which team member was responsible for tasks such as dispensing prescriptions for people that were waiting for them, working on the medicines counter and answering the telephone. One of the trainee dispensers focused primarily on services for the care home, and assisted in other tasks such as multi-compartment compliance packs when other team members were absent.

The pharmacy team were observed throughout the inspection, and they were working very hard throughout. But they struggled to keep up with demand from people using the pharmacy. Prescriptions were not always ready for collection when the person expected it to be, and the waiting area was busy whilst people waited for their prescription to be dispensed or for a team member to be available to carry out a service. The team explained that three team members had planned absence on the day of the inspection so there would usually be eight people working at the pharmacy, but instead they had five. Insufficient staff planning, the lack of training on how to use the new computer system, a lack of computer terminals, and the increased time it took to dispense prescriptions for the care home due all had a negative impact on the productivity of the pharmacy team.

Holidays were discussed with other team members and authorised by the pharmacy manager. The pharmacy manager checked the rotas in advance to see if any amendments were required, however, the minimum staffing levels and skills mix were not adequately reviewed to ensure that the team can manage the workload. Pharmacy team members completed ongoing training and training needs were identified to align with new services, seasonal events, and the NHS Pharmacy Quality Scheme (PQS). An eLearning system was used for training. The team had annual appraisals with the pharmacy manager.

The pharmacy staff said that they could raise any concerns or suggestions with any of the pharmacists

or the pharmacy manager and felt that they were responsive to feedback. Team members said that they would speak to head office, or GPhC if they ever felt unable to raise an issue internally. The team were unsure how to share feedback about the new computer system and they had not considered contacting any of their colleagues in the other pharmacies within the group to ask whether they had found a solution to the issues that they have identified.

The RP was observed making himself available to discuss queries with people when requested, or with people on the telephone. Some targets for professional services were set and the team thought that these were sensible targets and attainable.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean and tidy, and it provides a suitable environment for the delivery of healthcare services. It has a consultation room, so that people can speak to the pharmacy team members in private when needed.

Inspector's evidence

The public facing areas of the premises were smart in appearance and appeared to be well maintained. Maintenance issues were reported to head office. The pharmacy had two separate rooms to the back of the dispensary that were not in the same state of repair as the rest of the premises. One room was used to store medicines waste, confidential waste and had a large number of dispensed prescriptions in tote boxes that had been removed from the shelves. As these had not been collected, they were due to be unpacked and put back into stock when the team had time. The back door of this room was labelled as a fire exit and had signage displayed on the door to alert the team to not block the door, however, this was blocked with a chair and an empty cosmetics fixture. The RP agreed to move these as soon as possible. The other room was used by a dispensing assistant as a base for care home dispensing and administration.

The dispensary was an adequate size for the services provided; an efficient workflow was seen to be in place. Dispensing and checking activities took place on separate areas of the worktops and on a large central workbench. The pharmacy had air conditioning and the temperature in the dispensary felt comfortable. Lighting was adequate for the services provided. Prepared medicines were stored securely, and pharmacy medicines were stored behind the medicines counter.

There was a private soundproof consultation room and was professional in appearance. The door to the consultation room remained closed when not in use to prevent unauthorised access. The pharmacy was clean and tidy with no slip or trip hazards evident. It was cleaned by pharmacy staff. The sinks in the dispensary and staff areas had running water, hand towels and hand soap were available.

Principle 4 - Services **Standards not all met**

Summary findings

The pharmacy offers a range of healthcare services which are easy and convenient for people to access. But the implementation of the new computer system means that there is a backlog in some of the less urgent pharmacy workload as it is taking the pharmacy team longer to do their day-to-day tasks. The new system makes it harder for the pharmacy team to dispense prescriptions for the care home that it supplies medicines to, and there are underlying issues with how the pharmacy, care home and surgery work together to provide effective care for the care home residents. The pharmacy obtains its medicines from licensed suppliers, and stores them securely and at the correct temperature, so they are safe to use. People receive appropriate advice about their medicines when collecting their prescriptions.

Inspector's evidence

The pharmacy had step free access from the pavement and a limited home delivery service was available to people who could not access the pharmacy. Health promotion leaflets were available, and posters were displayed around the premises. Pharmacy staff referred people to other local services using local knowledge and the internet to support signposting.

An automated collection point had been installed at the front of the pharmacy that allowed people to collect their prescriptions at a time that was convenient to them. People were sent a text message containing a collection code when the prescriptions was put into the machine. Some medicines had been identified as not being suitable for the collection point. For example, controlled drugs, cold-chain medicines, and prescriptions that required additional counselling.

The team were aware of the risks associated with the use of valproate containing medicines during pregnancy, and the need for additional counselling. Patient cards and counselling materials were available, supplied to people when appropriate and valproate containing medicines were supplied in their original packaging.

The pharmacy offered the NHS Pharmacy First service. The team had undergone training and they had quick reference guides available and the NHS PGDs (patient group directions) and supporting documentation had been printed for reference. The RP used the flow chart supplied by NHS England during his consultations to demonstrate the rationale for the advice that he gave. He explained that this helped manage people’s expectations and that they could see the reason why he may not have recommended antibiotics.
Various private pharmacy services were available. Some were carried out by the pharmacist, and some were carried out by appropriately trained pharmacy team members. Consent forms were completed prior to administering vaccinations and records were maintained. The main private services were travel vaccinations and ear wax removal. Patient Group Directions were available for reference and named the RP as being authorised for the service.

The barcode on each of the medicines was scanned during the dispensing stage and the system only

printed off a dispensing label if the medication scanned was correct. A clear warning message was displayed on the screen if it was incorrect. NHS prescriptions were downloaded electronically, and this information was used for the dispensing and labelling process which reduced the risk of a member of the pharmacy team entering incorrect information into the system. There were additional processes for split packs, packs without barcodes and certain medicines that the team had identified as high-risk, such as controlled drugs. The pharmacy had three computer terminals in use; one was in the office and was being used by the RP for clinical checking, one was used by a dispenser for dispensing walk-in prescriptions and queries, and one was used by a dispenser for dispensing repeat prescriptions. This meant that the other dispensers did not have computer terminals to use and were often observed waiting to use a computer which reduced their productivity. The dispensers did not appear to be switching between user accounts which would reduce the reliability of the PMR's inbuilt audit trail.

Prescription items were dispensed into baskets to ensure prescriptions were not mixed up together. There was a quick response (QR) code on the dispensing label and the computer system recorded which member of the team had been involved in each stage, so there was a dispensing audit trail for prescriptions. The layout of the dispensary and positioning of the computer terminals meant that the RP was based in the back office and may reduce the amount of opportunistic counselling or interventions made by the pharmacist.

The pharmacy supplied medicines to a 71-bed care home. The care home was separated into different areas dependent on the level of care required by the resident. The pharmacy was responsible for ordering and dispensing the monthly medicines into single medicine packs for the residents. The pharmacy ordered the repeat prescriptions from the surgery, checked them against the request, and sent them to another pharmacy in the group to be dispensed. This other pharmacy was known as "the hub" and the hub had an automated machine that dispensed medicine packs for the rest of the pharmacies within the group. The dispensed medicine packs were returned to the pharmacy for onward supply. Until recently, a dispensing assistant had been visiting the care home once a month so that she was up to date with anything that she would need to know before the pharmacy supplied the next monthly tray packs. This had stopped due to staffing shortages at the pharmacy. The RP and dispenser explained that neither the care home team nor the surgery team routinely made the pharmacy aware of medicine changes. The RP and dispenser explained that neither the care home team nor the surgery team routinely made the pharmacy aware of medicine changes. This meant that members of the team spent a considerable amount of time dealing with queries and medication changes

To reduce medicine waste, the surgery had requested that the care home order any 'external' medicines themselves. These were medicines that were not dispensed into the monthly tray packs. External items included creams, inhalers, and dressings. The pharmacy was not informed when these prescriptions had been ordered and was dependent on the care home following up on anything that was not prescribed. The team were experiencing difficulties with the new PMR not differentiating between monthly medicines, external items, and acute prescriptions and how to supply them if the surgery had prescribed an external item on the same prescription form as a monthly medicine. There was a risk that the process in place for supplying the care home, in its current form, could lead to a delay in medicines being available for the residents or medicines being supplied incorrectly.

A random sample of dispensary stock was checked, and all the medicines were found to be in date. Medicines were stored in an organised manner on the dispensary shelves. All medicines were observed being stored in their original packaging. Split liquid medicines with limited stability once they were opened were marked with a date of opening. Patient returned medicines were stored separately from stock medicines in a designated area. Medicines were obtained from a range of licenced wholesalers. Drug recalls were received electronically.

The controlled drug cabinet was secure and a suitable size for the amount of stock that was held. Medicines were stored in an organised manner inside. Fridge temperature records were maintained, and records showed that the pharmacy fridges were working within the required temperature range of 2°C and 8°Celsius.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide services safely. But the number of computer terminals available is a barrier to productivity for the pharmacy team members. The pharmacy team stores and uses the equipment in a way that keeps people's information safe.

Inspector's evidence

The pharmacy had access to a range of up-to-date reference sources, including the British National Formulary (BNF) and the children's BNF. Internet access was available. Patient records were stored electronically. The pharmacy team members waited to use the pharmacy computers on multiple occasions so it appeared they did not have enough terminals for the workload currently undertaken. A range of clean, crown stamped measures and counting triangles were available.

Equipment for clinical consultations had been procured and was stored appropriately. Some of the equipment was single use, and ample consumables were available. Computer screens were not visible to members of the public. Cordless telephones were in use and staff were observed taking phone calls in the back part of the dispensary to prevent people using the pharmacy from overhearing.

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.