General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Riddings Pharmacy, 31 Greenhill Lane, Leabrooks, ALFRETON, Derbyshire, DE55 1LU

Pharmacy reference: 1107650

Type of pharmacy: Community

Date of inspection: 26/10/2023

Pharmacy context

This busy community pharmacy is located close to a medical practice in the centre of the village. Most people who use the pharmacy are from the local area and a home delivery service is available. The pharmacy dispenses NHS prescriptions, and it sells a range of over-the-counter medicines. It supplies a large number of medicines in multi-compartment compliance aid packs to help people take their medicines at the right time. And it provides a wide variety of additional services including Covid-19 vaccinations.

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 adequately manages risks, and it takes steps to improve patient safety. It completes the records that it needs to by law and asks its customers for their views and feedback. Members of the pharmacy team work to professional standards, and they are clear about their roles and responsibilities. They generally keep people's private information safe, and they understand how to protect the welfare of vulnerable people.

Inspector's evidence

The pharmacy had up-to-date standard operating procedures (SOPs) for the services it provided, with signatures showing that members of the pharmacy team had read and accepted them. A new member of the team confirmed that she had been given time to read the SOPs when she started working at the pharmacy. Roles and responsibilities were set out in SOPs and the pharmacy team members were performing duties which were in line with their roles. Team members were wearing uniforms. The name of the responsible pharmacist (RP) was not displayed, but the pharmacist superintendent (SI), who was working as the RP, printed a notice off and displayed it during the inspection.

The pharmacy team recorded near misses on a log. They were reviewed by the SI and learning points were discussed with the team. A dispenser described the actions taken following a near miss when she selected the wrong strength of gabapentin. The team had separated the different strengths, to remind people to take extra care when selecting them. The look-alike and sound-alike drugs (LASAs) amitriptyline and amlodipine had been separated to avoid confusion between them. A dispensing incident form was completed on the patient medication record (PMR) if a dispensing error occurred. Following an incident involving a delivery error, the team had reviewed the delivery process and the delivery driver had re-read the delivery SOP.

There was a notice on display highlighting the pharmacy's complaint procedure and encouraging people to give feedback. A current certificate of professional indemnity insurance was on display. Private prescription records and the RP record were electronic and appeared to be in order. The controlled drug (CD) registers were appropriately maintained. Records of CD running balances were kept and these were periodically audited. Two CD balances were checked and found to be correct. Adjustments to methadone balances were made and attributed to manufacturer's overage if within a reasonable range. The SI explained that he would carry out an investigation if the overage was outside of this range.

Confidential waste was collected in designated places and then sealed in bags until it was collected by an external company for shredding. The new member of staff had a basic understanding about patient confidentiality and said the SI had explained this when she started working at the pharmacy. A privacy statement was on display, in line with the General Data Protection Regulation (GDPR). Assembled prescriptions were stored appropriately so that people's details could not be seen by members of the public. Some paperwork containing confidential information was stored in the consultation room which was accessible from the retail area. The SI locked the door when this was pointed out to avoid any potential breaches of confidentiality.

A member of the team confirmed she had completed some training on safeguarding said she would discuss any concerns regarding children and vulnerable adults with the pharmacist working at the time. She explained a situation when, after discussing with the pharmacist, she had contacted a patient's GP because she was worried about their failing memory. She had made a note of this intervention on the patient's medication record. Another team member was aware of the 'Safe Space' initiative, where pharmacies offer to provide a safe space for victims of domestic abuse. She was not sure if the pharmacy had registered to take part in this scheme, but she confirmed that the consultation room was always available for anyone requiring a confidential conversation. The pharmacy had a chaperone policy, and a notice highlighted this to people.

Principle 2 - Staffing ✔ Standards met

Summary findings

Pharmacy team members work well together in a busy environment, and they have the right training and qualifications for the jobs they do. Team members are comfortable providing feedback to the superintendent pharmacist and they receive feedback about their own performance.

Inspector's evidence

There was a pharmacist (SI), an NVQ2 qualified dispenser, two trainee dispensers, a medicines counter assistant (MCA), and a trainee MCA on duty at the time of the inspection. The staffing level was adequate for the volume of work during the inspection and the team were observed working collaboratively with each other and people who visited the pharmacy. Most of the team worked part-time so there was flexibility with their hours and team members could work extra hours when necessary. There was also a pharmacy technician (PT) and a delivery driver on the pharmacy team, but they were not present at the inspection. The SI worked full time as RP in the pharmacy and a regular locum pharmacist covered the SI's day off each week.

Members of the pharmacy team carrying out the services had completed appropriate training. One of the trainee dispensers had just finished a dispensing assistant course. She explained that she had carried out a lot of course work at home, but the SI had been supportive and had provided some protected training time during working hours. Team members had access to an online learning platform to keep their knowledge up to date. Recent topics covered included antibiotic stewardship, adult and childhood obesity, cancer, and flu vaccinations. The pharmacy provided Covid-19 vaccinations. These were administered by non-pharmacist team members under the national protocol. The SI confirmed that the team members were competent to do this and had carried out the required training which included face-to-face as well as online training.

There was a formal appraisal process where performance and development were discussed, and team members also received feedback informally from the pharmacy manager. One of the trainee dispensers said she had a performance review after she had worked at the pharmacy for around three months. Informal team meetings were held where a variety of issues were discussed, and concerns could be raised. Team members felt there was an open and honest culture in the pharmacy and confirmed they would feel comfortable talking to the SI about any concerns they might have. They said they could also seek advice from the company's HR team. The staff worked well as a team and could make suggestions or criticisms informally. A dispenser said she felt comfortable admitting errors and tried to learn from them.

The pharmacists were empowered to exercise their professional judgement and could comply with their own professional and legal obligations. For example, refusing to sell a pharmacy medicine containing codeine, because they felt it was inappropriate. Team members were not under pressure to achieve targets.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy provides a suitable environment for people to receive healthcare services. It has a private consultation room so people can receive services in private and have confidential conversations with members of the pharmacy team.

Inspector's evidence

The pharmacy premises, including the shop front and facia, were clean, and in a good state of repair. The retail area was free from obstructions, professional in appearance and it had a waiting area with some chairs. The temperature and lighting were adequately controlled. The fixtures and fittings were in good order. There was a separate stockroom where excess stock was stored. Staff facilities included a small kitchen area, and a WC, with a wash hand basin and antibacterial hand wash. There was a separate dispensary sink for medicines preparation with hot and cold running water. The consultation room was equipped with a sink. The room was also used as an office and it was quite cluttered, which compromised the professional image. The availability of the room was highlighted by a sign on the door. This room was used when carrying out services such as vaccinations and when customers needed a private area to talk.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy offers a wide range of healthcare services which are generally well managed and easy for people to access. The pharmacy gets its medicines from licensed suppliers, and it carries out some checks to ensure medicines are in good condition and suitable to supply. But the compliance aid pack service could be managed more effectively to ensure people always take their medicines safely.

Inspector's evidence

The pharmacy, consultation room and pharmacy counter were accessible to everyone, including people with mobility difficulties and wheelchair users. A list of the services provided by the pharmacy was displayed in the window, along with the opening hours. There was a range of healthcare leaflets. The pharmacy supplied prescription only medicines (POMs) under private and NHS Patient Group Directives (PGDs). For example there were PGDs for erectile dysfunction (ED), urinary tract infections (UTI), skin infections and children's eye infections. The SI was a pharmacist independent prescriber (PIP), and he supplied some POMs on private prescriptions. He explained that his scope of practice included upper respiratory infections and he showed details of a consultation where he had prescribed antibiotics for a chest infection. The SI explained that he did not generally inform the patient's usual prescriber when he prescribed, and he left the onus on the patient to let their GP know. This meant the person's usual prescriber might not always be aware that people had been treated by the pharmacy and received a prescription. The SI said he would consider sharing information such as this with the person's GP, going forward, if the person consented to this. The SI kept written records of the prescribing he carried out and the supplies he made under PGDs, including the details of the consultation he had with the patient.

The pharmacy provided a home delivery service. Daily delivery sheets were available showing which people had received deliveries, but the delivery driver did not obtain a signature from the recipient or record their name or the time of the delivery, so this might make it harder to understand what had gone wrong in the event of a query or problem. If nobody was available to receive the delivery, a note was left, and the medicine was returned to the pharmacy.

Space was quite limited in the dispensary, but the workflow was organised into separate areas and the dispensary shelves were reasonably well organised, neat, and tidy. Dispensed by and checked by boxes were initialled on the medication labels to provide an audit trail. Different coloured baskets were used to improve the organisation in the dispensary and prevent prescriptions becoming mixed up. The baskets were stacked to make more bench space available.

Stickers were put on assembled prescription bags to indicate when a fridge line or CD was prescribed. 'Pharmacist' stickers were used to highlight when counselling was required. The valproate information pack and care cards were available to ensure people in the at-risk group were given the appropriate information and counselling.

The pharmacy supplied some people with their medication in multi-compartment compliance aid packs. Some packs which were delivered on a weekly basis were assembled in advance of the prescription, using the previous prescription as a guide. This increased the risk of errors, and they were not labelled until the prescription was received, which meant they were stored without labels. The SI explained that

this was because the GP practices didn't get the prescriptions to the pharmacy in adequate time to allow assembly of the compliance aid pack each week. He agreed to review this practice and discuss the timings with the GP practices. There was a partial audit trail for changes to medication in the packs, but it was not always clear who had confirmed these, which could cause confusion in the event of a query. Medicine descriptions were usually included on the labels to enable identification of the individual medicines. Packaging leaflets were not usually included unless the medication was new to the patient. So, people might not have easy access to all of the information they need. Disposable equipment was used.

The MCA explained what questions she asked when making a medicine sale and when to refer the person to a pharmacist. She was clear which medicines could be sold in the presence and absence of a pharmacist and understood what action to take if she suspected a customer might be misusing medicines such as a codeine containing product.

CDs were stored in a CD cabinet which was securely fixed to the wall. Date expired, and patient returned CDs were segregated and stored securely. Pharmacy medicines were stored behind the medicine counter so that sales could be controlled. There was an unsealed sharps bin in the consultation room which was a potential health and safety hazard. The SI locked the consultation room when this was pointed out to prevent harm from used sharps.

Recognised licensed wholesalers were used to obtain stock medicines. Medicines were stored in their original containers at an appropriate temperature. Expired and unwanted medicines were segregated and placed in designated bins. Alerts and recalls were received via email messages. A copy was retained in the pharmacy with a record of the action taken so the team were able to respond to queries and provide assurance that the appropriate action had been taken.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

Members of the pharmacy team have access to the equipment and facilities they need for the services they provide. They maintain the equipment so that it is safe to use. But they could improve the monitoring of the fridge temperatures to ensure medicines requiring refrigeration are always stored at the correct temperature.

Inspector's evidence

The pharmacist could access the internet for the most up-to-date information such as the electronic British National Formulary (BNF) and BNF for children. There were two clean medical fridges for storing medicines. The minimum and maximum temperatures was recorded daily for one of the fridges and had been within range throughout the month. The second medical fridge had recently been obtained, and although a team member checked the minimum and maximum temperatures, they were not recorded, so they could not demonstrate that it had remained at the correct temperature. There was a third fridge which contained the staff's food, but it was also being used to store vaccines. The SI said this was a temporary measure as both the medical fridges were full. He said he checked this fridge's temperature every day, but he did not record it. The vaccines were moved to one of the medical fridges during the inspection and the SI confirmed that he would ensure that they were both monitored, and the minimum and maximum temperatures would be recorded on a daily basis. All electrical equipment appeared to be in good working order and had been PAT tested.

There was a selection of clean glass liquid measures with British standard and crown marks. Separate measures were used for methadone solution. The pharmacy had a range of clean equipment for counting loose tablets and capsules. And a separate tablet triangle that was used for cytotoxic drugs. Medicine containers were appropriately capped to prevent contamination. Computer screens were positioned so that they weren't visible from the public areas of the pharmacy. PMRs were password protected. Cordless phones were available in the pharmacy, so staff could move to a private area if the phone call warranted privacy.

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.