General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Graham Young Chemist (2007) Ltd, Graham Young Memorial, Medical Village, Lincoln Road, PETERBOROUGH, PE1 3HA

Pharmacy reference: 1108491

Type of pharmacy: Community

Date of inspection: 11/03/2020

Pharmacy context

This community pharmacy is located on the same site as a busy doctors' surgery, on a main road not far from the centre of Peterborough. Its main activity is dispensing NHS prescriptions and most of these prescriptions are issued by the adjacent surgery. It delivers some of these prescriptions to people at home. And it supplies some medication in multi-compartment compliance packs to help people manage their medicines better. The pharmacy sells a range of medicines over the counter. It also offers a needle exchange service and has a small number of people receiving medicines as part of a substance misuse service.

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	Good practice	3.1	Good practice	The premises are fitted to a very good standard and there is ample space for the pharmacy to provide its services safely.
		3.2	Good practice	The pharmacy has good facilities to protect the privacy of people using its services.
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 manages and identifies risks in the pharmacy to make sure its services are safe. Its team members learn from their mistakes to reduce risks during the dispensing process. They protect people's information. And they know what actions to take if they have concerns about vulnerable people. The records that the pharmacy must keep by law are generally well-maintained.

Inspector's evidence

Pharmacy services were supported by a set of written standard operating procedures (SOPs). The procedures included management of controlled drugs (CDs), responsible pharmacist (RP) procedures, dispensing some higher-risk medicines, and sales of over-the-counter medicines. Those checked had been reviewed within the last two years. And there was information about staff roles and responsibilities in the SOPs. There was a signature sheet attached to each procedure which staff signed to show they had read the document. In some cases, staff had not signed this sheet. And in other cases, the date of signing was some years before the most recent review. This makes it harder for the pharmacy to demonstrate that staff are fully aware of and are following its current procedures. However, during the inspection, staff appeared to be working in a safe and organised way. Prescriptions were dispensed using baskets to prevent the inadvertent transfer of items between different people. Prescription labels seen, including those on multi-compartment compliance packs, were initialled at the dispensing and checking stages to create an audit trail showing who had been involved in these tasks. And areas of the pharmacy were used for separate tasks such as dispensing and checking prescriptions and preparing compliance packs, to reduce the risk of distractions.

The pharmacists and accuracy checking technicians (ACTs) pointed out to team members any dispensing mistakes they picked up during the accuracy check of prescriptions (referred to as near misses). This was so staff could rectify these themselves, wherever possible, and make a record of the event to help them reflect and learn from their mistake. Near miss records showed that mistakes were recorded routinely. Common near misses were shared with the team to reduce similar mistakes happening. But the level of detail about how or why a mistake happened was often missing from the records. And learning points were mostly 'double check', 'concentrate' or 'slow down'. Where the wrong medicine had been selected, the records did not show what the correct item should have been as a comparison. The lack of all these details could make it harder for the pharmacy to use the records to spot any patterns or trends and address any specific learning needs or risks in the pharmacy environment. However, the pharmacy had taken preventative actions including highlighting the storage locations of medicines which sounded or looked alike to reduce selection errors. There was also a procedure to record and report dispensing errors and to learn from these to prevent similar events in the future. Notes were added to people's medication records to make sure dispensers knew about previous errors and were particularly vigilant when dispensing these prescriptions.

When asked, members of the team could explain what they could and couldn't do when the pharmacist was not present. They also knew the types of medicines that could be liable to abuse and under what circumstances they needed to refuse to supply or refer requests for these medicines to the pharmacist for further advice.

The pharmacy gathered customer feedback though an annual patient satisfaction survey; results of the most recent survey were displayed in the pharmacy and were positive about the service provided to people. There was information about the pharmacy's complaints procedure displayed in the pharmacy. And there was signposting information for people about the Patient Advice and Liaison Service (PALS). Staff had an SOP about dealing with complaints which they could refer to; this had been reviewed in March 2019.

The pharmacy had current professional liability and public indemnity insurance. Records about CDs were kept and largely complied with legal requirements. Running balances of CDs were also kept and were generally checked regularly. The stock of an item checked at random agreed with the recorded amount. The pharmacy had a separate register for patient-returned CDs. Returned medicines were recorded and destroyed promptly. Records about the RP were kept and included the pharmacists' registration numbers but only referred to shortened first names rather than the pharmacists' full names. The RP notice on display showed the correct details for the pharmacist on duty and could be seen by people visiting the pharmacy.

The pharmacy was registered with the Information Commissioner's Office. People who wanted to have a private conversation with the pharmacy staff were offered the use of the consultation rooms; these were signposted from the shop floor. There was a written procedure about protecting confidentiality and a poster was displayed for people using the pharmacy, explaining how their information was protected. Sensitive information was stored out of the reach and sight of the public and confidential waste was disposed of securely. The IT system was password protected. Staff were using their own NHS smartcards and passwords to access electronic prescriptions and did not share details about their passwords.

There were some procedures in place to help make sure the pharmacy took appropriate action to protect vulnerable people though it was some time since staff had read these. And it wasn't clear if the procedures covered adults as well as children. Registrants had completed level 2 training about safeguarding. Other members of staff said they would refer any concerns to the ACTs or the pharmacists. Team members had completed 'Dementia Friends' training so they had a better understanding of how to assist people living with this condition. There were contact details for local safeguarding agencies so the pharmacy could report concerns promptly.

Principle 2 - Staffing ✔ Standards met

Summary findings

Pharmacy team members are suitably trained for the roles they undertake. There are enough of them to cope with the pharmacy's workload. Team members learn from each other and they have people they can discuss queries or concerns with if needed.

Inspector's evidence

It was busy throughout the visit, with most of the work coming from the adjacent surgery. The pharmacy's team members were coping with the workload. They discussed queries with each other and referred to the pharmacist where needed. The pharmacy team consisted of two regular pharmacists, one of whom was the superintendent and the RP at the time of the inspection. There were also two trained accuracy checking technicians (ACTs), eight trained dispensers, and a trained medicine counter assistant. There were several certificates displayed which reflected the training that staff had completed. The ACTs could identify those prescriptions which were suitable for them to accuracy check. If the RP dispensed a prescription, she asked for a second independent accuracy check to reduce the risk of errors.

Staff retention was good. The team had annual appraisals to discuss their performance and to identify any additional learning needs. They also received ad hoc feedback from the pharmacists on a regular basis. The RP explained how the team members were currently focussed on ensuring they were competent in their existing roles and tasks rather than looking to undertake additional pharmacy qualifications.

There were mechanisms to share information across the pharmacy team. There were sometimes team briefings to share important messages. If members of staff could not attend these, the pharmacists provided memos to those who missed the briefings to make sure they received the same information. There were examples provided of information that had been shared and staff had been asked to sign a briefing sheet to show they had been kept informed. When asked, team members said they had regular discussions about any issues or incidents in the pharmacy, so they could share learnings. They said they felt comfortable about raising any concerns with the pharmacists or ACTs. There were no targets which might adversely impact on pharmacy professionals being able to exercise their professional judgement, or to act in the best interests of their patients.

Principle 3 - Premises ✔ Good practice

Summary findings

The pharmacy's premises are safe, secure, and suitable for the services it provides. They are well-maintained and present a very professional appearance to people visiting the pharmacy. There is ample space for all the pharmacy’s activities. And the premises protect people’s privacy well.

Inspector's evidence

The premises were spacious, well-organised and very clean. All areas were maintained to a suitable standard. The dispensary sink used for preparing medicines was clean and had hot and cold running water. There were appropriate hygiene facilities for staff. The premises were accessible to people with mobility issues or those with prams or wheelchairs. And there was a good amount of customer seating available for people waiting for services. Room temperatures throughout the premises were controllable, and levels of ventilation and lighting were appropriate for the activities undertaken.

The premises could be secured outside of opening hours. Members of the public could not readily access the dispensary or get behind the medicines counter. Dispensed medicines were kept out of reach of the public. Sections of the dispensary and rooms off this area were reserved for specific activities, such as preparing multi-compartment compliance packs and processing deliveries, to reduce risks in the dispensing process. There were two well-screened consultation rooms which were signposted from the retail area. These rooms were kept locked when not in use. There was a further screened area with a hatch through to the dispensary and this facility was used for supervised consumption and needle exchange services. This area was clean and harm reduction posters were displayed. It provided people accessing these services with a good level of privacy.

Principle 4 - Services ✔ Standards met

Summary findings

Overall, the pharmacy provides its services safely. It prepares multi-compartment compliance packs for people in an orderly way. And it has good systems to make sure medicines are delivered correctly to people. To ensure its medicines are fit for purpose, the pharmacy gets them from reputable sources and stores them correctly. It doesn't always keep a record of when it date checks its stock. So, it may be harder to know that all stock is checked regularly. And it could do more to ensure that people who receive higher-risk medicines get all the advice they need to take their medicines safely.

Inspector's evidence

Information about coronavirus and reducing the spread of infection was clearly displayed at the entry to the pharmacy. The pharmacist explained that the pharmacy had been receiving multiple queries from people about ordering additional supplies of medicines. The pharmacy team was trying to provide reassurance to people and discouraging them from stockpiling medicines.

The pharmacy offered a prescription delivery service to assist housebound and elderly people access their medicines. There were good records kept for the delivery service and these included signatures from some recipients. Notes were left for people if they were not in and the medicines returned to the pharmacy. A separate record was kept for controlled drugs delivered.

Multi-compartment compliance packs were provided to some people who needed this level of support to manage their medicines at home. These were prepared largely by two dispensers, in a designated part of the dispensary. The pharmacy ordered prescriptions on behalf of people for medicines to be put into the packs, so the pharmacy had enough time to prepare them. Missing items or unexpected changes on prescriptions were queried with the patient or their GP and the pharmacy kept a record of these for future reference. Labelling on the packs included tablet descriptions, doses and warnings. And patient information leaflets (PILs) were supplied routinely. The dispensers could explain the types of medicines that were not suitable for dispensing in the packs. For example, warfarin or other medicines with variable doses. There was an audit trail on the packs to show who had dispensed and checked them. Dispensers did not start to prepare packs until all the stock was available.

Staff were able to say how long prescriptions for CDs were valid for. Uncollected prescriptions were checked every month and removed from the retrieval area to prevent people from collecting prescriptions which may no longer be valid or appropriate for the person to take. Prescriptions for all dispensed medicines were attached to the bags but prescriptions for CDs and other higher-risk medicines were not highlighted to the staff. This could make it harder for staff to make appropriate checks when handing these medicines out to people. A member of staff said that checks were made with a patient when they were first supplied warfarin or methotrexate, to make sure the person knew the correct dose to take and had information about possible side effects that should be reported. However, similar checks were not made routinely on subsequent supplies. When asked, an ACT could explain the advice to give to people about pregnancy prevention when supplying valproate medicines. The pharmacy had the relevant educational literature available to give to people.

Most pharmacy services were advertised to people through posters and leaflets on display. There were also some leaflets and posters giving information about other healthcare support services or services not provided by the pharmacy. The pharmacist explained that the pharmacy team had a very good working relationship with the surgery next door, including the practice pharmacist who came to the pharmacy to discuss a query during the inspection. This meant that issues or queries could be resolved promptly.

Medicines were obtained from licensed wholesalers and specials were obtained from specials manufacturers. No extemporaneous dispensing was carried out. There was ample storage space for medicines, and they were stored in a well-organised manner. Controlled drugs requiring secure storage were stored appropriately and there was good key control in place. Pharmacy medicines were stored out of reach of the public. The medicines fridge was equipped with a maximum and minimum thermometer and temperatures were checked daily and recorded. The recorded temperatures were within the appropriate range. The pharmacy had the equipment it needed to verify medicines, in line with the Falsified Medicines Directive. The pharmacist explained that they were not able to scan all medicines as not all packs carried the correct barcode. Date checking was said to be carried out regularly. There were records kept about medicines that were short-dated so these could be removed from stock at an appropriate time. However, there were no records to show which parts of the dispensary had been dated checked or when this had been done. This could make it harder for the pharmacy to be sure that all areas are checked regularly. Out-of-date medicines and patient-returned medicines were transferred to designated bins and stored separately from dispensing stock. A spot check of stock at random found one date-expired medicine amongst dispensing stock; this was destroyed straightaway. Medicines were kept in appropriately labelled containers.

The pharmacy could show that most recent drug recalls and safety alerts about medicines had been received. An ACT explained what steps were taken when the pharmacy received these. And there was an audit trail to evidence that appropriate actions had been taken to protect patient safety. However, there was no record of the pharmacy receiving an alert about the recall of Emerade 150 microgram pens. When checked during the inspection, the pharmacy had none of the affected item in stock. The ACT said she would register to receive alerts direct from the MHRA as an additional check.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has access to the equipment and facilities it needs to provide its services safely. And it keeps its equipment clean. The facilities available for storing medicines which need to be refrigerated should be kept under review.

Inspector's evidence

The pharmacy had a range of up-to-date reference sources available to assist with clinical checks and other services. Measuring equipment of a suitable standard was available; some glass measures were marked for specific use to prevent cross-contamination. A pump was used to measure instalment doses of methadone. There was a process to clean this and check it was measuring volumes accurately. But there was no record about this, making it harder for the pharmacy to demonstrate they were following good practice. Patient medication records were stored electronically. Screens for the pharmacy computers were not visible to the public. The pharmacy had cordless phones and team members could make phone calls out of earshot of waiting customers if needed. The fridge used to store medicines was operating within the appropriate temperature range. However, there was little capacity for any increase in stock or dispensed medicines which may need to be refrigerated.

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.