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: 23/02/2023

Pharmacy context

This community pharmacy is located adjacent to a busy medical centre, on a main road not far from the centre of Peterborough. Its ownership has recently changed, and it is now owned by the same owners of the medical centre. Its main activity is dispensing NHS prescriptions and most of these prescriptions are issued by the adjacent medical centre. It delivers some of these prescriptions to people at home. And it supplies some medication in multi-compartment compliance packs to people who need this support. It participates in the Community Pharmacist Consultation service. It 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	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 generally identifies and manages the risks associated with its services. It has made changes to address operational problems and improve the service it provides to people. It has up-to-date procedures which tell staff how to work safely and it has systems in place to make sure its team members have read these. It generally makes the records it needs to by law. And its team understands the need to keep people's information private. The pharmacy tries to learn from dispensing mistakes to reduce the chance of similar incidents happening again. The records about mistakes that are spotted early and corrected could be improved to make the most of these opportunities to further develop safer ways of working.

Inspector's evidence

The pharmacy had written standard operating procedures (SOPs) for staff to support safe ways of working. These had been developed using standardised templates, and the superintendent (SI) said he had reviewed these to make sure they reflected local practice. The SOPs were held electronically and there was a process to track that members of the team had read the procedures. Staff were seen to follow carry out dispensing activities in an organised way. And there was an audit trail kept showing that prescriptions were clinically screened, and accuracy checked before being handed out to people. Prescriptions were initialled by the team members who screened, dispensed, and checked them. The pharmacy's team members were aware of when they needed to refer queries to the responsible pharmacist (RP) and were seen doing so during the inspection. They understood what they could and couldn't do if there was no RP at the pharmacy. And they could explain the restrictions on sales of some products, including medicines containing codeine. The pharmacy did not sell codeine linctus or Phenergan and the team was aware of the abuse potential of these medicines.

The pharmacy kept a record about mistakes made and corrected during the dispensing process (near misses). The records seen had limited information about why mistakes had happened. The SI was the RP during the inspection. He accepted the records could be improved to make more of the opportunity to learn and improve from these events. The SI could explain how a dispensing mistake which had reached a patient was dealt with. This included correcting the mistake and looking after the patient, making a record of the incident, and reporting it to the pharmacy's insurers who then fed anonymised information into the national reporting system so patterns and trends could be identified at a higher level. The SI provided evidence of how errors reported to the pharmacy had been recorded and reviewed to prevent similar mistakes happening in the future. There was also a monthly review of dispensing incidents and details of this including any learnings were shared with the team members through staff briefings.

The pharmacy had a complaints procedure. The SI and new owner said the team was focussed on improving on the service the pharmacy provided to people. They accepted there had been operational issues following the change of ownership and the pharmacy had not always coped well with its dispensing workload. There had been long waiting times for people using the pharmacy's services and some delays in providing medication to people. This had resulted in poor reviews on social media and a number of concerns to the regulator about how the pharmacy was managing. The pharmacy had made changes to the layout of the dispensary and how repeat prescriptions were managed to make the

dispensary more efficient. Changes had also been made to the stock ordering processes to try to supply medicines to people without delay wherever possible. The SI and new owners said many of the earlier issues had now been largely resolved but the team was keen to continue to improve the service it provided to people.

The pharmacy had professional indemnity and public liability insurance in place. A poster showing details about the RP on duty was displayed where people visiting the pharmacy could see it. And it was correct. The record about the RP was available and was complete. Private prescriptions were recorded electronically. Some records about these did not include the right information about the prescriber. And some prescriptions were not included in the private prescription record as they had been recorded as NHS prescriptions. The SI said he would address this with the team straightaway. Records viewed about controlled drugs (CDs) were up to date. Running balances were recorded and checked regularly. The recorded stock of an item chosen at random agreed with physical stock. CDs returned by people for destruction were recorded as soon as they were received. There was an audit trail for destroyed CDs. CD discrepancies identified had been reported to the CD Accountable Officer (CDAO).

When asked, staff understood the need to keep people's information private. There were written procedures to protect people's information, and these had been read by the staff. Computer screens containing patient information could not be seen by the public. Confidential waste was separated from normal waste and was disposed of securely.

To ensure vulnerable people were protected, pharmacists and accuracy checking technicians had completed level 3 safeguarding training. And they knew how to report safeguarding concerns. Other members of the team had read the SOP about safeguarding. There was a safeguarding lead at the surgery. The pharmacy had raised concerns about a person's memory with their GP to make sure the person got the support they needed.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough staff with the right skills to cope with its current workload. The pharmacy's team members work closely together and communicate well with each other, sharing information appropriately to make the pharmacy's services safer. And they are suitably trained or are undertaking the right training for the roles they undertake. Pharmacy professionals can exercise their professional judgement and have the necessary support in place to help them undertake their roles safely.

Inspector's evidence

The RP on duty during the inspection was the new SI. He and two other employed pharmacists provided most of the pharmacist cover in the pharmacy. There were also practice-based pharmacists in the adjacent surgery who could provide additional support when needed. The rest of the pharmacy team comprised two accuracy checking technicians (one full-time and one part-time), four full-time trainee pharmacy technicians, three full-time trained dispensing assistants, four full time trainee dispensers, and two delivery drivers. The team members were all relatively new to this pharmacy and were getting more familiar with the way the pharmacy worked. They appeared able to cope with the current workload and people visiting the pharmacy during the inspection were served with reasonable promptness. And trainee members of staff had been enrolled on the right accredited training for their roles.

The SI explained how he had investigated the roles and responsibilities of an SI when taking on the new role and he had peer support from a more experienced pharmacist consultant which he had found very helpful. He was also able to discuss operational matters with the pharmacy owners and practice manager and could make decisions to improve how the pharmacy operated. The pharmacists had provided feedback to the surgery when Community Pharmacist Consultation Service (CPCS) referrals to them were outside of the service's remit. This was to reduce inconvenience to people and make sure people got the right care in as timely a way as possible.

The staff took it in turns to undertake various tasks such as dispensing and serving people at the front counter. Staff commented that they had experienced quite a lot of aggression and abuse at times which had been very difficult to cope with. But this had subsided more recently. The accuracy checking technician explained how she and the other checking technician switched tasks to help make sure they didn't make mistakes or lose concentration through fatigue or repetition. Team members in training were seen asking more experienced members of staff for assistance with queries and they appeared to be very supportive to each other. The pharmacy had not yet established formal systems to review staff performance aside from people completing a probationary period at the start of their employment. The pharmacy had team meetings to share details about incidents and share improved ways of working. If needed, similar information was passed on to team members through individual briefings.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises are suitable for the safe provision of pharmacy services and are maintained appropriately. The pharmacy has good facilities for people wishing to have a private conversation with members of the pharmacy team.

Inspector's evidence

The entrance to the pharmacy was at street level and the automatic-opening door was wide enough to accommodate prams or wheelchairs. The shop floor area was clear of clutter and there were no trip hazards. Some retail display shelves had been removed to create more space for people waiting for pharmacy services. Access to the dispensary was restricted. Members of staff had good visibility of the medicine counter and pharmacy-only medicines were stored out of reach of the public. The pharmacy could be secured against unauthorised access. People’s information on dispensed items waiting to be collected could not be seen by members of the public.

The dispensary was very spacious, and the premises were well-maintained throughout. The SI explained how the layout had been changed to help with workflow and to make more efficient use of the storage space. There was ample storage space for stock and dispensed items. There were multiple dispensing benches, and these were designated for specific activities to manage the workflow. Public-facing areas and the dispensary were clean. The private consultation facilities were a good standard and provided a place for people to have private conversations and access pharmacy services in a suitable environment.

The room temperature was appropriate for storing medicines and could be controlled. Lighting was suitable for safe dispensing. The pharmacy team members had access to appropriate hygiene facilities and rest areas. The sink in the dispensary used for reconstituting medicines was clean.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy has made improvements to how it operates as a result of things not working well. And, overall, it manages its services effectively. It has introduced new processes to monitor stock availability to try to make sure it can supply medicines to people in a timely way. It stores its medicines appropriately. And it has good processes in place to make sure the medicines it supplies are safe for people to use.

Inspector's evidence

The pharmacy's opening hours were displayed at the entrance. There was some health information literature about self-care displayed in the retail area. And there was ample seating available for people waiting for pharmacy services. This had been extended in recent months by removing retail displays. The pharmacy delivered medicines to some people; by delivery drivers and by post. Due to customer service issues following the change of ownership, the pharmacy had extended its delivery services to more people. The delivery driver kept a record of the medicines they delivered to show that medicines had reached the right people. Medicines sent out by post were packaged discreetly to protect people's privacy. The pharmacy team knew that fridge lines and CDs could not be sent by post.

Baskets were used to keep prescriptions for different people separate. Different coloured baskets were used to prioritise workload. And some dispensing benches were allocated to designated days so that batch prescriptions could be checked in date order. The ACT explained that she and the other ACT rotated through tasks such as accuracy checking and dispensing working to reduce slips in concentration. The team members also took it in turns to work on the front counter to share workload. There was an audit trail on prescriptions to show who had completed each step of the process from clinical screening to accuracy checking. And the bag label for CD prescriptions indicated when the prescription was valid to meaning this could be checked easily before handout.

The pharmacy supplied medicines in multi-compartment compliance packs to people who lived in their own homes. The number of people supplied these had dropped in recent months. The dispensers prepared these packs in a separate, quieter part of the dispensary to reduce risk. They had individual records for the people receiving these packs and added notes to these records when there were changes or other interventions. The packs seen were labelled with the dose and a description of the medicines added. There was an audit trail on the packs to show who had dispensed and checked each pack. Patient information leaflets were supplied every four weeks.

The pharmacy had most of the current safety literature about pregnancy prevention for people taking valproate-containing medicines. But it did not have any spare warning stickers to apply to plain boxes. The SI explained that they would always dispense in the manufacturers' original packs so the right information was available to people. The pharmacy had completed a valproate audit and had identified three patients who could be in the at-risk group. These and any new patients were counselled by the pharmacists if a prescription for these medicines was received. One of the pharmacists was able to describe the types of checks they would make when supplying other higher-risk medicines such as methotrexate. This included asking about possible side-effects. There were alert stickers available so pharmacists could highlight prescriptions that needed additional counselling when they were handed

out.

Medicines were obtained from licensed suppliers. The pharmacy admitted that there had been significant stock issues after the change of ownership. And this had caused delays in dispensing prescriptions for people and additional work for the team members. The pharmacy had subsequently changed its ordering processes and the system now adopted had resulted in improved stock availability. Medicines were stored very tidily in the dispensary. Waste medicines were stored in designated bins. There was some evidence that medicines with short shelf-lives were highlighted, and a new rota had been created to make sure all parts of the pharmacy were date-checked regularly. But this had only been introduced recently and some parts of the dispensary had yet to be date-checked. The SI said that stock had been moved around a lot in the last three months as the pharmacy was improving its layout. He was confident that stock had been date-checked at the same time as this was done. When stock was spot-checked, there were no out-of-date medicines found.

Staff understood the need to keep medicines in appropriately labelled containers so they could date-check effectively and respond to drug recalls efficiently. Uncollected items were assessed for suitability to return to stock. Medicines that required refrigerated storage were kept in the pharmacy's fridges, located within the dispensary. Maximum and minimum fridge temperatures were monitored and recorded for the fridges and had remained within the required range. There was enough storage capacity in the fridges and no evidence of ice build-up.

The pharmacy received safety alerts and recalls about medicines from several sources including MHRA and local NHS alerts. The SI explained that, on change of ownership, the pharmacy had reviewed previous safety alerts and recalls, going back several months, to make sure that no affected stock could be supplied.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs to provide its services safely. It keeps sensitive information on out of view of the public to protect people's confidentiality.

Inspector's evidence

The electronic patient medication record system was only accessible to pharmacy staff and computer screens could not be viewed by the public. Members of the team used their own smartcards to access electronic NHS prescriptions and did not share their cards. The pharmacy had cordless phones, and staff could move to private areas to hold phone conversations out of earshot of the public. Computer screens and dispensed prescriptions waiting collection could not be seen from the shop area.

Staff had a range of reference sources to use, including online resources, so advice provided to people was based on up-to-date information. The equipment used for measuring liquids, was of an appropriate standard and was generally clean. Counting triangles were clean and one was reserved for counting methotrexate to prevent cross-contamination.

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.