General
Pharmaceutical
Council

Registered pharmacy inspection report

Pharmacy Name: Phakeys Pharmacy, 149 Carlton Road, NOTTINGHAM, Nottinghamshire, NG3 2FN

Pharmacy reference: 1109436

Type of pharmacy: Community

Date of inspection: 01/11/2022

Pharmacy context

This is a community pharmacy that is situated on a road leading out of the city centre. Most of its activity is dispensing NHS prescriptions and selling medicines over the counter. The pharmacy supplies medicines in multi-compartment compliance packs to people who live in their own homes. Other services that the pharmacy provides include delivering medicines to people's homes and the Community Pharmacist Consultation 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

Overall, the pharmacy identifies and manages the risks associated with the provision of its services. Its team members work safely but because the pharmacy's written procedures are not regularly reviewed there is a risk that they might not always work as effectively as they could. The pharmacy has some procedures to learn from its mistakes. But because it doesn't record its near misses it might miss opportunities to improve its ways of working.

Inspector's evidence

The pharmacy had a set of standard operating procedures (SOPs) which were currently under review. The pharmacist had not yet introduced SOPs for new NHS services such as the Discharge Medicines Service. But staff were seen dispensing medicines and handing medicines out to people safely. Staff understood how to sell medicines safely and knew the advice to give during a sale. Staff knew that prescriptions were valid for six months apart from some controlled drugs (CDs) which were valid for 28 days. The pharmacy had processes in place to make sure medicines that were no longer valid were not handed out to people.

The pharmacy had some processes for learning from 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 but were not being recorded in the near miss log as required by the SOP. The pharmacy maintained the necessary records to support the safe delivery of pharmacy services. These included the responsible pharmacist (RP) record and the private prescription book. Records about schedule 2 CDs were kept and were largely complete; there were minor instances of missing headers in some registers. The entries for two items checked at random during the inspection agreed with the physical stock held. Up to June 2022, balance checks had been completed regularly each month. More recently, these had not been completed as frequently due to staffing issues. But there was evidence of occasional checks and appropriate investigations where balance discrepancies were spotted. Patient-returned CDs were recorded promptly on receipt in a designated register. Patient-returned CDs and date-expired CDs were clearly marked to prevent dispensing errors.

The pharmacy prepared instalment supplies at the start of the day when the pharmacy was quieter. It had suitable measuring equipment to make sure supplies were accurate. Supervised consumption at the pharmacy had largely continued throughout the pandemic. The pharmacy had considered the possible risks of supplying larger volumes to people to take at home, including the possibility of children in the home, before proceeding with these supplies.

The pharmacy had a complaints procedure and an information governance policy. Access to the electronic patient medication record (PMR) was password protected. Dispensed medicines that had not been collected were stored in boxes in the consultation room. These medicines had the names of people on the labels. This increased the risk that these names could be viewed by other people using pharmacy services. Confidential information was destroyed securely. Professional indemnity insurance was in place. The pharmacy understood safeguarding requirements and could explain the actions they would take to safeguard a vulnerable person.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy’s team members work well together to manage the day-to-day workload within the pharmacy. And they have the appropriate range of experience and skills. Team members can raise concerns if needed.

Inspector's evidence

The responsible pharmacist at time of the inspection was the regular, full-time pharmacist. The rest of the team comprised; three pharmacy technicians, four dispensing assistants, one pharmacy apprentice; two trained medicine counter assistants (both on long-term absence) and a trainee medicine counter assistant; two delivery drivers; and a cleaner. The long-term absences had put some additional pressure on the current team members and had meant that some routine jobs were not being done as often as they had been previously. It had also meant that set-aside time for team huddles was now often used to catch-up with work.

The pharmacy was busy throughout the visit, but the team was able to manage the workload, serving people promptly and working in an organised way. When asked, members of the team said they would be comfortable discussing any issues they had at work directly with the pharmacist. And they had regular contact with the superintendent and other people based at head office. Team members were observed referring queries to the pharmacist when needed. And they communicated well with each other throughout the visit.

The delivery driver could clearly explain what he would do if a person was not available to receive their medicine delivery. And he knew about the additional precautions to take with medicines requiring refrigeration. These would be taken out of the pharmacy’s fridge at the last moment before setting out to deliver and would be taken back to the pharmacy if a person was not at home.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy keeps its premises safe, secure, and appropriately maintained. And it has made changes to help keep its team members and people using the pharmacy safe.

Inspector's evidence

The pharmacy premises presented a positive image to the people using it. There was a modern facia outside the pharmacy. Inside the public area was neat and tidy with suitable seating and plenty of space for people using the pharmacy to wait. There was a clear plastic screen at the pharmacy counter which provided re-assurance to both the staff and the customers. And there was hand sanitiser available. The dispensary was a suitable size for the services provided. There was adequate heating and lighting, and hot and cold running water was available.

A reasonable sized consultation room was available for people to have a private conversation with pharmacy staff. However the room had several boxes full of medicines on the floor and was generally cluttered. It presented a less professional image. Unauthorised access to the pharmacy was prevented during working hours and when closed.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's healthcare services are suitably managed and are accessible to people. The pharmacy team show care and concern for people using its services. The pharmacy gets its medicines and medical devices from reputable sources. It stores them safely and it knows the right actions to take if medicines or devices are not safe to use to protect people's health and wellbeing. But the pharmacy doesn't always make a record of action it has taken in response to an alert. This makes it harder for the pharmacy to demonstrate how it has protected people.

Inspector's evidence

The pharmacy had suitable access to allow people with a disability or a pushchair to get into the pharmacy. The pharmacist was easily accessible and during the inspection engaged with people visiting the pharmacy. 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 using the pharmacy's services. This included advice when they had a new medicine or if their dose changed. The pharmacist didn't make records when he spoke to people who took medicines that required ongoing monitoring such as warfarin or methotrexate. This could mean helpful information is not available for other pharmacy staff to refer to.

The pharmacy used a dispensing audit trail which included use of 'dispensed by' and 'checked by' boxes on the medicine label to help identify who had done each task. Baskets were used to keep medicines and prescriptions for different people separate to reduce the risk of error. The pharmacy supplied multi-compartment compliance packs to a large number of people to help them take their medicines at the right time. The pharmacy had a waiting list for new people who wanted to use this service as it was currently at capacity to manage the workload safely. There was sufficient lead time to prepare packs and the pharmacy spread the workload across the month, using a tracker to make sure packs were prepared and supplied on time. Packs were labelled with doses and warnings but, due to time pressures, the pharmacy did not include medicine descriptions on the packs. This could make it harder for people to identify individual medicines in their packs. Patient information leaflets were provided to people each month. Each person had an individual record sheet and team members recorded any changes on this sheet. The sheet then accompanied the packs during the dispensing processes, so the pharmacist had the right information available when completing clinical and accuracy checks. The pharmacy also had good access to information about hospital admissions and discharges and changes to people's medicines when this happened. A dispenser was able to describe the types of medicines they wouldn't include in the packs due to stability issues.

Medicines were stored tidily on shelves in their original containers. Opened bottles of liquid medications were marked with the date of opening so that the team would know if they were still suitable for use. The pharmacy team had a process for date checking medicines. A check of a small number of medicines didn't find any that were out of date. CDs were stored appropriately. A record of invoices showed that medication was obtained from licensed wholesalers. The pharmacist explained the process for managing drug alerts but didn't always make a record of the action taken. He said that she would start making a record.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

Members of the pharmacy team have the equipment and facilities they need for the services they provide. They maintain the equipment so that it is safe to use.

Inspector's evidence

The pharmacy used suitable measures for measuring liquids. The pharmacy had up-to-date reference sources. Records showed that the fridge was in working order and stored medicines within the required range of 2 and 8 degrees Celsius. The pharmacy's portable electronic appliances had been tested recently to make sure they were safe.

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.