General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Priory Fields Pharmacy, Priory Fields Surgery, Nursery Road, HUNTINGDON, Cambridgeshire, PE29 3RL

Pharmacy reference: 1109945

Type of pharmacy: Community

Date of inspection: 09/01/2020

Pharmacy context

This community pharmacy is located beside a busy doctors' surgery, close to the town centre and on a busy road. It stays open longer in the evening than the surgery. Its main activity is dispensing NHS prescriptions, with most of the people who use the service coming from the adjacent surgery. The pharmacy supplies a large number of people with their medicines in multi-compartment compliance packs to help them manage their medicines. The pharmacists provide seasonal flu vaccinations. And there are a quite a few people who receive supervised administration services at the pharmacy. The pharmacy also delivers medicines to some people at home.

Overall inspection outcome

✔ **Standards 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 met	1.2	Good practice	The pharmacy team members regularly record and review mistakes that happen when dispensing so they can learn from these and improve.
2. Staff	Good practice	2.3	Good practice	Pharmacy professionals use their professional judgement and take decisions that benefit people's health and wellbeing.
		2.4	Good practice	The pharmacy team members receive regular feedback about their performance. And they are encouraged to learn from their mistakes in an open and honest way.
3. Premises	Standards met	N/A	N/A	N/A
4. Services, including medicines management	Standards met	4.1	Good practice	The pharmacy team work closely with the surgery next door to make sure their services are effective. And people can get the help and advice they need from this pharmacy when other sources of support are closed.
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 written procedures and these were last reviewed in May 2019. The procedures included management of controlled drugs (CDs), responsible pharmacist (RP) procedures, dispensing higher-risk medicines, and sales of over-the-counter medicines. The audit trail showing that staff had read procedures had been completed on those documents viewed. Staff roles and responsibilities were included in each of the procedures, though the task matrix for this team had not been filled in.

Prescriptions were dispensed using baskets to prevent the inadvertent transfer of items between different people. Baskets of different sizes and colours were used to prioritise the workload. Prescription labels observed, 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. 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.

There was a procedure to record and report dispensing errors to the pharmacy's head office. The pharmacy manager explained how errors were managed to make sure people's care was prioritised and improvements made to reduce similar incidents happening again. The pharmacists pointed out to team members any dispensing mistakes they picked up during the accuracy check of prescriptions (referred to as near misses) so staff could rectify these themselves wherever possible. Near misses were recorded and reviewed regularly. Common near misses were shared with the team to reduce similar mistakes happening. Preventative actions included highlighting the storage locations of medicines which sounded or looked alike to reduce selection errors. The pharmacy also received newsletters from their head office and information contained in these about common mistakes or other safety matters were shared with the team.

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 being analysed. There was also a device on the counter to capture on-the-spot feedback about the service provided. There was information about the pharmacy's complaints procedure displayed in the pharmacy.

The pharmacy had current professional liability and public indemnity insurance. Records for private

prescriptions, emergency supplies, and CDs were kept electronically and largely complied with legal requirements. The pharmacy had a separate register for patient-returned CDs. The most recent entries in this register were not complete; the record had not been updated when some items had been destroyed and some returned items awaiting destruction had yet to be entered. The pharmacist said she would make sure the record was brought up to date. Records about private prescriptions did not always include the required information about the prescriber. Records about the RP were complete and the RP notice on display showed the correct details for the pharmacist on duty.

People who wanted to have a private conversation with the pharmacy staff were offered the use of the consultation room and this room was signposted. There was a written procedure about protecting confidentiality and a leaflet for people using the pharmacy explaining how their information was protected. Staff received refresher training about protecting information. 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.

There were procedures in place to help make sure the pharmacy took appropriate action to protect vulnerable people. Registrants had completed level 2 training on safeguarding and other members of staff had completed training relevant to their roles. The pharmacy manager explained how the delivery driver had reported back concerns about people they had visited. The pharmacy had contacted the person to check on their wellbeing and had raised concerns with the person's GP where appropriate.

Principle 2 - Staffing ✔ Good practice

Summary findings

Pharmacy team members are suitably trained or are undertaking appropriate training for the roles they undertake. And they are given good support to help keep their skills and knowledge up to date. The team members learn from each other and they have people they can discuss queries or concerns with if needed. Pharmacy professionals are able to use their judgement to make sure services are safe and effective.

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. A dispenser explained that members of the team regularly changed the tasks they completed so everyone in the team kept their skills and competencies current.

The pharmacy team consisted of the pharmacy manager (the RP at the start of the inspection), two additional pharmacists (one of whom came on duty part-way through the inspection), seven trained dispensers, a trainee dispenser, a trained medicine counter assistant, and two delivery drivers. Two of the dispensers had just been started on an accuracy checking course. The pharmacy manager explained this extra skill would increase the capacity of the pharmacists to focus on additional services to people.

The staff in training were completing accredited courses relevant to their roles and one of the pharmacists acted as a tutor for this training. The pharmacy manager explained that a few of the staff had started with little or no pharmacy experience and he was proud of how they had developed in their roles. Staff retention was good. The team had appraisals every six months to check on their progress and performance in addition to regular informal discussions with the pharmacists.

There were several certificates displayed which reflected the training that staff had completed. These included dispensing courses and health improvement courses. The company provided ongoing training to staff to help them keep their skills and knowledge current. These included updated SOPs, and eLearning modules which were issued to the team every month. Some of this training was considered mandatory by the company, and there was a process to check that staff had completed it. Staff said they sometimes got time at work to do training. This was mainly in the evenings when the surgery was closed or at other quieter times.

When asked, the team members said they had regular discussions about any issues or incidents in the pharmacy, so they could share learnings. Some agenda points and notes had been kept from previous meetings; the most recent notes were from August 2019. The team said they could make suggestions about how to improve the pharmacy and these would be acted on where appropriate. They also felt comfortable about raising any concerns with the regional support manager who visited the branch regularly.

The pharmacy manager explained that he felt able to exercise his professional judgement when delivering services, putting safety and the needs of patients first. He had considered the pharmacy's ability to take on any new people requiring multi-compartment compliance packs. He felt that the

pharmacy was currently at maximum capacity, given the limited space available, and the service was not being actively promoted. However, he would take individual patient need into account if approached. He also described interventions he had made on prescriptions which had resulted in improved care for people.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy's premises are safe, secure, and suitable for the services it provides. There is just about enough space for staff to cope with the current workload.

Inspector's evidence

The premises were relatively small for the volume of prescriptions dispensed. But the pharmacy was reasonably clean and maintained to a suitable standard. The dispensary sink used for preparing medicines was reasonably clean and had hot and cold running water. The pharmacy team shared staff facilities with the medical centre. The premises could be secured outside of opening hours. The premises were accessible to people with mobility issues or those with prams or wheelchairs. And there was some customer seating available for people waiting for services.

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 were reserved for specific activities, such as preparing multi-compartment compliance packs, to reduce risks in the dispensing process. The dispensary area, benches and prescription storage areas were reasonably well-organised, but some of the bench space was taken up by stacks of baskets containing prescriptions waiting to be dispensed or checked. Several boxes of stock and dispensed items had to be kept on the floor of the dispensary due to lack of other storage space. These did not pose a trip hazard though did make it harder to move about the premises.

A small but well-screened consultation room was available and signposted. This was kept locked when not in use and there was no patient identifiable information on display in the room. There was just enough space in the room to allow for a chaperone to accompany a patient, if needed. However, there was no information displayed for people that the pharmacy had a chaperone policy.

Room temperatures in the premises were controllable, and levels of ventilation and lighting were appropriate for the activities undertaken.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's services are accessible to people with different needs and its services are available when other pharmacies are closed. And overall, it provides its services safely. It takes particular care with medicines that may be higher-risk so people get the advice they need. To ensure its medicines are fit for purpose, the pharmacy gets them from reputable sources and stores them correctly. But 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.

Inspector's evidence

The pharmacy was open from 7am to 10.30pm Monday to Saturday and 10am to 5pm on Sundays. These extended opening times meant that people could get healthcare advice at this pharmacy when the surgery and other local pharmacies were closed. The pharmacist explained that they often made emergency supplies out of hours and had received some referrals through the Community Pharmacy Consultation Service. A prescription delivery service was offered to assist housebound and elderly people access their medicines. And multi-compartment compliance packs were provided to a large number of people who needed this level of support to manage their medicines at home. Services were advertised to people through posters and leaflets on display. There were also some posters giving information about other healthcare support services or services not provided by the pharmacy.

The pharmacy manager explained that the pharmacy team had a very good working relationship with the surgery next door. This meant that queries could be resolved promptly. In the past, he had given talks to patient groups at the surgery, explaining the pharmacy services available to them.

Prescriptions for higher-risk medicines were flagged using alert stickers so staff could make appropriate checks when handing these out. This included prescriptions for controlled drugs and medicines such as warfarin which needed close therapeutic monitoring. There was evidence that the correct alert stickers were used in practice. And, when asked, the team members knew how long prescriptions for Schedules 2, 3 and 4 CDs were valid for. The pharmacist knew about the advice to give to people about pregnancy prevention when supplying valproate medicines. They had completed an audit of their patients. And the pharmacy had the educational literature available to give to people. The pharmacist said they would order more of the warning stickers to apply to dispensed items. For those people receiving methadone in supervised instalments, there was a process to record and report missed doses to the drug support team. The pharmacy manager explained how he had withheld doses where people had shown signs of intoxication, to prevent harm.

The pharmacists had completed the necessary training for a wide range of services offered under patient group directions (PGDs) but only the flu vaccinations were offered regularly. The pharmacy kept copies of the PGD documents so these could be referred to when providing the services. Due to manufacturing issues with adrenaline auto-injectors, the pharmacy had adrenaline vials available as an alternative to treat possible anaphylactic reactions following a flu vaccination. However, the pharmacy did not keep syringes with the vials. This could introduce an unnecessary delay in responding to such events.

Compliance packs were prepared in the main 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. The surgery generally sent notes to the pharmacy about any changes 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. And no tablets that were hygroscopic. There was an audit trail on the packs to show who had dispensed and checked them; the packs were usually dispensed and checked on the same day.

There were records kept for the delivery service and these included signatures from some recipients. The driver signed for those people unable to do so themselves. A separate record was kept for controlled drugs delivered.

Medicines were obtained from licensed wholesalers and specials were obtained from specials manufacturers. No extemporaneous dispensing was carried out. There was limited storage space for medicines but most of them were stored in an orderly fashion in the dispensary on shelves. Some bulkier items were stored in boxes on the floor due to lack of space on shelves. Pharmacy-only medicines were stored out of reach of the public. The two medicines fridges were equipped with maximum and minimum thermometers and temperatures were checked daily and recorded. The recorded temperatures were within the appropriate range. The pharmacy team was not yet scanning products to verify them, in line with the Falsified Medicines Directive. When asked, staff were still to receive any training about this.

Date checking was said to be carried out regularly though records were not always kept when this was done. Short-dated medicines were recorded, and stickers applied to these so they could be readily identified when dispensing and date checking. 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 no date-expired medicines amongst dispensing stock. And most medicines were kept in appropriately labelled containers. One opened bottle of Oramorph did not show the date it had first been used. This would make it harder for dispensers to know it was still suitable to dispense; it was removed for destruction when this was pointed out. Appropriate arrangements were in place for storing CDs securely.

The pharmacy could show that recent drug recalls and safety alerts had been received. A dispenser 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 following recent recalls involving ranitidine products.

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. Its equipment is generally well-maintained.

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. There was a small amount of powder residue on the tablet counting triangle used for methotrexate; this was cleaned as soon as it was pointed out.

All electrical equipment appeared to be in good working order and had been safety tested within the last six months. The pharmacy was not currently offering testing services such as blood pressure checks. People were signposted to the surgery where there was a blood pressure machine available to use.

Patient medication records were stored electronically. And there was access to these records in the consultation room. 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.

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.