General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Chess Pharmacy, 260-290 Berkhampstead Road, CHESHAM, Buckinghamshire, HP5 3EZ

Pharmacy reference: 1111846

Type of pharmacy: Community

Date of inspection: 28/05/2024

Pharmacy context

This is a community pharmacy inside a large medical centre in a residential area on the outskirts of Chesham, Buckinghamshire. The pharmacy dispenses NHS and private prescriptions, sells over-the-counter medicines, and provides health advice. It also offers a range of services such as the New Medicine Service (NMS), local deliveries, blood pressure checks, seasonal flu as well as COVID-19 vaccinations and Pharmacy First.

Overall inspection outcome

✔ **Standards met**

Required Action: None

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	1.8	Good practice	The pharmacy's team members actively ensure the welfare of vulnerable people. The pharmacy can demonstrate that it has taken appropriate action in relation to concerns identified, the relevant processes are in place to assist with this, and team members are suitably trained.
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 suitably. Team members actively protect the welfare of vulnerable people. The pharmacy protects people's confidential information appropriately. And the pharmacy largely keeps the records it needs to by law. Members of the pharmacy team deal with their mistakes responsibly. But they are not always documenting and formally reviewing the necessary details. This could mean that they may be missing opportunities to spot patterns and prevent similar mistakes happening in future.

Inspector's evidence

The pharmacy had current standard operating procedures (SOPs) which provided the team with guidance on how to carry out tasks correctly. The staff had read and signed them. Members of the pharmacy team understood their roles well and worked in accordance with the company's set procedures. Team members had set tasks but rotated where needed to efficiently manage the workload. Staff were observed to work independently of the responsible pharmacist (RP) in separate areas of the pharmacy. The correct notice to identify the pharmacist responsible for the pharmacy's activities was on display.

The pharmacy effectively safeguarded the welfare of vulnerable people. Staff were trained appropriately, this included the regular, responsible pharmacist (RP). Team members could recognise signs of concerns; they monitored people who used their services and knew who to refer to in the event of a concern. Staff also described concerns seen as well as how they had responded. It was evident that members of the pharmacy team were vigilant towards the people who used their services, and examples were provided where they had actively assisted or safeguarded vulnerable people. Contact details for the local safeguarding agencies were easily accessible.

The pharmacy's team members had been trained to protect people's confidential information. The team ensured confidential information was protected, they had signed confidentiality clauses. No sensitive details were left in the retail area. Confidential information was stored and disposed of appropriately. Computer systems were password protected and team members used their own NHS smart cards to access electronic prescriptions.

The pharmacy largely had suitable internal processes and systems to identify and manage risks associated with its services. The RP described handling dispensing incidents which reached people and complaints in a suitable way, the relevant details were recorded and investigated appropriately. To help minimise internal mistakes, one dispenser worked at the front of the dispensary, and predominantly dealt with people waiting for prescriptions or queries. Other dispensing staff were based at stations behind this area where they split the workload between them and processed prescriptions in batches. They checked relevant details on prescription(s) before processing, identified any changes or interactions and ensured a three-way accuracy check took place between the prescription(s), generated dispensing label and medicine(s).

Staff explained that the pharmacy had a strong learning environment. The RP routinely handed back dispensed medicines for staff to identify their near miss mistakes. The pharmacy had installed an automated dispensing system (robot) since the last inspection and visit by the GPhC. This had helped

minimise mistakes. However, team members explained that mistakes occurred when the packaging on medicines looked-alike and they were then subsequently incorrectly loaded into the robot. After identifying and highlighting this kind of near miss mistake, all stock within that section of the robot was removed and checked. The RP described a formal review of each near miss mistake occurring with the team. However, near miss mistakes were not routinely recorded, nor were details collated and reviewed formally which could help identify any trends or patterns.

Team members highlighted that the pharmacy routinely received positive feedback from people using its services and that this was highlighted on the town's social media. This was said to be down to the service provided by the RP who was frequently mentioned on these pages and by staff. The RP explained that he treated people using the pharmacy's services the way he would have expected if he was in their position and team members increasing looked out for people using their services. This was demonstrated through the way they safeguarded vulnerable people and delivered some of the pharmacy's services (see Principle 4).

The pharmacy's records were mostly compliant with statutory and best practice requirements. This included a sample of registers seen for controlled drugs (CDs). On randomly selecting CDs held in the cabinet, their quantities matched the stock balances recorded in the corresponding registers. The pharmacy had suitable professional indemnity insurance arrangements in place. Records verifying that fridge temperatures had remained within the required range had been appropriately completed. However, the RP record had gaps and staff were not entering details within the private prescription register within the correct period.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has an adequate number of staff to manage its workload safely. The pharmacy's team members are suitably trained or now undertaking the appropriate training. But the pharmacy delivers ongoing training in an unstructured way. This could affect how well the team conduct tasks and adapt to change with new situations.

Inspector's evidence

The pharmacy team consisted of the regular RP, three dispensing assistants, two of whom were enrolled onto appropriate, accredited training courses, two medicines counter assistants (MCAs) and a volunteer who loaded medicines by scanning them into the automated dispensing system. The team's certificates of qualifications obtained were seen and their competence was demonstrated. This was a busy pharmacy due to the pharmacy's location. The pharmacy had plenty of staff to support the workload, the team was up to date with this, and people were observed to be served promptly.

However, at the point of inspection, the volunteer had worked at the pharmacy for the past two years but had not been enrolled onto any accredited training for the activities he was currently undertaking. This was therefore not in line with the GPhC's 'Requirements for the education and training of pharmacy support staff'. This specifies that support staff must be enrolled on a training course as soon as practically possible and within three months of starting their role. However, confirmation was received following the inspection that the company had subsequently enrolled this member of staff onto the appropriate accredited training.

The MCA asked relevant questions before selling medicines. They knew which medicines could be abused or had legal restrictions and sales of these medicines were monitored. Staff knew when to refer to the pharmacist appropriately. They communicated verbally with regular discussions, daily meetings, and used an electronic messaging application. There were also opportunities available for staff to lead on services or progress with further training. Team members in training were provided with protected time to complete their accredited training courses at work. Some resources for ongoing training were available through pharmacy support organisations, via the RP or through trade publications. This helped members of the pharmacy team to keep their knowledge up to date, but the training was not delivered or monitored in a structured way.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises provide a suitable environment for people to receive healthcare services. The pharmacy is kept clean. And it has a separate space where confidential conversations or services can take place.

Inspector's evidence

The pharmacy premises were attached to the medical centre and included a small retail area with two entry points, two consultation rooms, and a medium sized dispensary. One side of the dispensary was taken up with the robot, this restricted but left an adequate amount of space to carry out dispensing tasks safely. The consultation rooms were signposted and of an appropriate size for their intended purposes. One was used by the RP for private conversations, this was accessible from the dispensary and somewhat cluttered with paperwork but still functional. The second was accessible from the retail area, it was very professional in its appearance and contained relevant equipment. The pharmacy was clean, parts of it could have been tidier but this was observed to be work in progress. The premises were bright, suitably ventilated, and presented appropriately. The ambient temperature was suitable for the storage of medicines. The pharmacy was secured against unauthorised access.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides its services safely. Members of the pharmacy team can make suitable adjustments to ensure everyone can use the pharmacy's services. The pharmacy sources its medicines from reputable suppliers. It stores and manages its medicines well. The pharmacy team regularly carry out interventions. This helps ensure people receive and take their medicines correctly. And team members routinely identify people who receive higher-risk medicines. But they don't always record any relevant information. This makes it difficult for them to show that people are provided with appropriate advice when these medicines are supplied.

Inspector's evidence

The pharmacy's opening hours were on display alongside some information and leaflets to promote health or services. People could enter the pharmacy through two ways. The first was through the medical centre which had steps leading into the pharmacy and the second via the front door. This was automatic, wide, and accessible from street level. The retail area consisted of clear, open space helped people with restricted mobility or using wheelchairs to easily access the pharmacy's services. There were chairs inside the pharmacy if people wanted to wait for their prescriptions and a car park available outside. Staff could make suitable adjustments for people with diverse needs, they would use simple language to aid people or offered the consultation room when required, spoke slowly and clearly to help people to lip read, and written communication was used for people who were deaf or partially deaf.

The workflow involved prescriptions being prepared by staff in designated areas and the RP checked medicines for accuracy from a separate area. The team used baskets to hold prescriptions and medicines during the dispensing process. This helped prevent any inadvertent transfer between them. The baskets were also colour-coded to highlight priority and different types of prescriptions. After the staff had generated the dispensing labels, there was a facility on them which helped identify who had been involved in the dispensing process. Team members routinely used these as an audit trail. Prescriptions for CDs were prepared when people arrived to collect them and dispensed medicines requiring refrigeration were stored within clear bags. This helped to easily identify the contents upon hand-out.

People's medicines were delivered to them, and the team kept records about this service through a specific application. Failed deliveries were brought back to the pharmacy, notes were left to inform people about the attempt made and in general, no medicines were left unattended. People occasionally requested for the latter to take place, staff made appropriate checks, documented details and could justify this practice when it had been required.

The pharmacy provided the Advanced NHS service, Pharmacy First. Relevant SOPs, service specification and Patient Group Directions (PGDs) to authorise this were readily accessible and had been signed by the RP. Suitable equipment was present which helped ensure that the service was provided safely and effectively (see Principle 5). The RP explained that he routinely communicated with the doctors in the adjacent medical centre through an electronic messaging application. They had subsequently agreed to issue medicines, where appropriate, for specific conditions and groups of patients under this service. This was due to the way people were managed at the medical centre so that the service could be

effectively monitored.

The pharmacy provided a blood pressure (BP) testing service. People could have their BP checked and their ambulatory BP could be monitored and checked over a 24-hour period through the pharmacy. The results were then sent to the GP surgery. This was led by a member of staff who had been appropriately trained to undertake this service. After completing the relevant training, this member of staff had, of her own volition, subsequently approached nurses from the adjacent medical centre to ask them to comment on her technique. This was said to be helpful. Staff routinely offered this service if they noticed people were exhibiting certain signs or symptoms. This included seeing blood-shot eyes for example. The service had identified people with extremely high, undetected BP and low BP where for example, headaches, feeling light-headed or visual disturbances were being experienced. The team referred appropriately with people seen by their GP within 24 hours, and they followed up on the outcome after medicines had been subsequently prescribed.

The team routinely made interventions. This ranged from identifying issues with people's prescriptions to effectively monitoring people who used their services (as described in Principle 1 and above). If incorrect medicines or strengths had been prescribed, they routinely approached the adjacent medical centre doctors and staff to amend in a timely manner. However, details of these interventions were not always recorded. Staff were aware of risks associated with valproates. They ensured the relevant warning details on the packaging of these medicines were not covered when they placed the dispensing label on them, and had identified people at risk, who had been supplied this medicine. People were counselled accordingly. The team also routinely identified and knew which people had been prescribed higher-risk medicines. Details about relevant parameters, such as blood test results for people prescribed these medicines were routinely asked about but this information was not recorded.

The pharmacy's stock was stored in an organised way. Licensed wholesalers were used to obtain medicines and medical devices. The team date-checked medicines for expiry regularly and kept records of when this had happened. Short-dated medicines were routinely identified. There were no date-expired medicines or mixed batches present. CDs were stored under safe custody and medicines were kept appropriately in the fridge. Medicines returned for disposal, were accepted by staff, and stored within designated containers. This did not include sharps which were re-directed accordingly. Drug alerts were received electronically and actioned appropriately. Records were kept verifying this.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the necessary equipment and facilities it needs to provide its services safely. And its equipment ensures people's private information is secure.

Inspector's evidence

The pharmacy had access to the necessary equipment and resources in line with its dispensing activity. This included access to current versions of reference sources, standardised conical measures, and a clean, dispensary sink, with hot and cold running water as well as hand wash. There was also a legally compliant CD cabinet along with appropriately operating fridges. The blood pressure machine was new as was relevant equipment for the Pharmacy First service. This included an otoscope, thermometer, and tongue depressors. The robot was serviced annually, routine maintenance was described, and the pharmacy had a back-up power supply in the event of a power failure. Lockers were available for staff to store personal belongings. Confidential waste was disposed of appropriately. The pharmacy's computer terminals were password protected and portable phones enabled phone calls to take place in private if required.

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.