General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Chestnut Pharmacy, Carcroft Health Centre, Chestnut Avenue, Carcroft, DONCASTER, South Yorkshire, DN6 8AG

Pharmacy reference: 1111987

Type of pharmacy: Community

Date of inspection: 10/07/2019

Pharmacy context

This village pharmacy is within a GP practice. The pharmacy is open until late six days a week. It sells over-the-counter medicines and it dispenses NHS and private prescriptions. The pharmacy also offers advice about the management of minor illnesses and long-term conditions. It supplies medicines in multi-compartmental compliance packs, designed to help people remember to take their medicines. And it delivers medicines to people's homes.

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 has procedures and processes in place to manage the risks associated with the services it delivers. But it does not review all procedures in a timely manner. This means that information within some procedures may not reflect the current practice of the pharmacy's team members. It generally keeps all records it must by law. But some gaps in these records occasionally result in incomplete audit trails. The pharmacy advertises how people can provide feedback about its services and it acts on this feedback appropriately. Pharmacy team members know how to protect vulnerable people. And they keep people's information secure. Pharmacy team members discuss the mistakes they make during the dispensing process. But they do not have access to up-to-date information to help inform shared learning following these mistakes.

Inspector's evidence

The pharmacy had a set of standard operating procedures (SOPs) in place. But these were overdue for review. The SOPs covered responsible pharmacist (RP) requirements, controlled drug (CD) management and services. They were accessible to pharmacy team members and all, but one member of the tea had signed them. The team member who had not signed the procedures explained he had signed a previous version before moving jobs and then returning to the pharmacy. He discussed his job role and explained how he would seek assistance from a senior member of the team before carrying out new duties. The pharmacy employed an accuracy checking technician (ACT). To support her role the pharmacist physically marked prescription forms to confirm a clinical check of the prescription was completed prior to the accuracy check. The ACT was confident in her role and explained how she would refer a prescription to the pharmacist, if she had a query.

Workflow in the dispensary was generally organised with separate benches used for managing acute and managed work. The RP had a protected area for carrying out accuracy checks. Pharmacy team members usually managed high-risk activities such as substance misuse dispensing and assembly of multi-compartmental compliance packs during quieter periods. This helped to reduce the risk of interruption and aided concentration.

The pharmacy team used an electronic reporting tool to record details of near-misses made during the dispensing process. But this was not working as intended. Near-miss data for the last six-months was not available to the pharmacy team. This meant that formalised reviews of near-misses locally had not been possible for some time. Pharmacy team members could demonstrate actions they had taken to reduce risk in the dispensary following regular discussions and feedback from near-misses. For example, the pharmacy had separated some 'look alike and sound alike' (LASA) medicines between the dispensary drawers and dispensary shelves to reduce the risk of a picking error occurring.

The pharmacy had an incident reporting procedure in place. The RP explained clearly how he would manage and report a dispensing incident. This included apologising to the person involved, establishing if there was the potential for harm and onward reporting to the prescriber when necessary. The pharmacy submitted incident reports to the 'National Reporting and Learning System'. This helped to inform national shared learning between pharmacies. The pharmacy team demonstrated how they had separated sumatriptan and sildenafil in the dispensary following a reported incident.

The pharmacy had a complaints procedure in place. And it provided details of how people could leave feedback or raise a concern about the pharmacy through its practice leaflet, available in the public area. A feedback box in the foyer of the pharmacy also allowed people to post comments anonymously. The pharmacy also engaged people in feedback through an annual 'Community Pharmacy Patient Questionnaire' and it published the results of this survey for people using the pharmacy to see. The pharmacy team had acted on some feedback by focussing on ensuring a member of the team was available to serve people in a timely manner.

The pharmacy had up to date indemnity insurance arrangements in place. The RP notice was updated at the beginning of the inspection to display the correct details of the RP on duty. Entries in the responsible pharmacist record complied with legal requirements. A sample of the CD register entries found that these generally met legal requirements. But wholesaler addresses were missing, when a CD was entered into the register. The pharmacy maintained running balances in the register and recorded balance checks against physical stock most weeks. A physical balance check of Zomorph 30mg capsules complied with the balance in the register. The pharmacy maintained a CD destruction register for patient returned medicines. And the team entered returns in the register on the date of receipt. But pharmacists and pharmacy team members did not always sign each individual entry when denaturing a CD. For example, multiple destructions were accompanied by one signature from the pharmacist and the pharmacy team member witnessing the destruction.

The pharmacy kept records for private prescriptions within its Prescription Only Medicine (POM) register. Occasional dates were missing from some entries. It recorded most emergency supplies electronically. But those completed through the NHS Urgent Medicine Supply Advanced Service (NUMSAS) and Pharmacy Urgent Repeat Medicine (PURM) service were not always entered as an emergency supply, and as such did not display in the electronic POM register. A discussion took place about the need to ensure an accurate record of these supplies was kept. And the RP confirmed this learning would be shared with other pharmacists. The pharmacy kept records relating to the supply of unlicensed medicines in accordance with the requirements of the Medicine and Healthcare products Regulatory Agency (MHRA).

The pharmacy displayed a privacy notice. Pharmacy team members had completed information governance training. And they explained how they applied this learning when protecting the confidentiality of people using the pharmacy. The pharmacy had submitted its annual NHS information governance toolkit and it disposed of confidential waste by using a shredder.

The pharmacy had procedures and information relating to safeguarding vulnerable people in place. This included information relating to Female Genital Mutilation (FGM). Pharmacy professionals had completed level 2 safeguarding training. Other members of the team had completed some learning on the subject. The delivery driver explained clearly how he would recognise and report any safeguarding concerns. Another member of the team explained how the pharmacy managed some concerns with prescribers. For example, if people regularly forgot to collect their medicine.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy generally manages its workload well. Pharmacy team members are either working towards, or have completed, accredited training for their roles. But the pharmacy occasionally allows a member of the team to undertake tasks beyond the level of training they have completed. This practice could increase risks during the dispensing process. The pharmacy gives staff time during working hours to complete ongoing learning. And team members are confident to make suggestions and provide feedback about the pharmacy.

Inspector's evidence

On duty at the time of the inspection was the RP (one of the pharmacy's regular pharmacists), an ACT, a level two qualified dispenser, a medicine counter assistant, a trainee medicine counter assistant and a delivery driver. Two regular pharmacists and some locum pharmacists provided pharmacist cover. The pharmacy also employed an apprentice (enrolled on a level three accredited pharmacy course), another two qualified dispensers and another driver. There was some flexibility between part-time members of the team for covering leave and unplanned absence.

The medicine counter assistant had previously been enrolled on a dispensing course and still undertook occasional dispensing tasks in the dispensary. A discussion took place about the risks of using untrained members of the team in the dispensary, even occasionally. And details of the GPhC guidance on the minimum training requirements for support staff was shared. Pharmacy team members reported they had the opportunity to participate in ongoing learning. This ranged from reading pharmacy media publications to attendance at local events. For example, smoking cessation refresher training. The pharmacy had an established appraisal system in place with its team members receiving annual reviews with the superintendent pharmacist.

The pharmacy did not have direct targets in place for the services it provided. Pharmacy team members helped identify people who may benefit from its services during the dispensing process. All pharmacy team members engaged people visiting the pharmacy in conversation during the inspection. The RP received positive feedback during the inspection from a member of the public, this followed the provision of counselling when handing out an assembled medicine.

The pharmacy team met monthly to discuss safety, roles and learning. But it did not record these discussions or any outcomes from these meetings. This meant staff not on duty when a meeting took place may miss the opportunity to share in this learning. The pharmacy did hold some full staff meetings. These took place periodically and were held on a Saturday evening. The pharmacy had a meeting scheduled to take place in July 2019. Pharmacy team members explained they would be discussing staffing levels and task management in the pharmacy as a member of staff had recently left.

The pharmacy had a whistleblowing policy in place. Pharmacy team member were aware of how to raise concerns and escalate these if needed. The pharmacy had adopted a prescription retrieval system following feedback from a member of the team who had used a similar system in a previous place of employment. The team demonstrated how the system worked well to help manage storage space and increase the efficiency of finding a bag of assembled medicines.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean and secure. It is small, meaning that some areas have become cluttered overtime. But pharmacy team members generally manage work space well.

Inspector's evidence

The pharmacy was clean and secure. The premises were suitably maintained, maintenance issues were reported to the superintendent pharmacist. There were no outstanding maintenance issues noted at the time of inspection. The public area was small and led directly to the medicine counter, it was accessible to people using wheelchairs or pushchairs. One door leading from the public area provided access to a signposted toilet. Another provided access to the pharmacy's consultation room, this was also clearly signposted. The consultation room was small and cluttered. This distracted from the overall professional appearance of the room. But the room was accessible to speak with people in private when required.

The dispensary was small for the volume of work undertaken, but work was spread across the pharmacy's extended opening hours which allowed staff to generally manage space well. Pharmacy team members had placed a few baskets containing part-assembled prescriptions on the dispensary floor. They explained this was due to clearing space to assemble a multi-compartmental compliance pack on a workbench. A discussion took place about the risks of holding baskets on the dispensary floor and these were appropriately relocated to a safe space. Air conditioning helped control temperature and lighting was adequate throughout the premises. Antibacterial soap and towels were available close to designated handwashing sinks.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy makes its services accessible to people and it supports people's health needs. The pharmacy manages its services adequately. But it does not always complete monitoring checks when dispensing high-risk medicines to help people take their medicine safely. The pharmacy obtains its medicines from reputable sources. And it stores and manages them appropriately to help make sure they are safe to use. It has some systems in place to provide assurance that its medicines are fit for purpose.

Inspector's evidence

People accessed the pharmacy at ground level through a shared entrance with the GP surgery. Parking was available directly outside the pharmacy. The pharmacy clearly displayed details of its opening times and services. It had a range of service and health information leaflets available to people. And there was a small amount of designated seating for people waiting for a prescription or service. Pharmacy team members could explain how they would signpost people to other local pharmacies or healthcare services if they were unable to provide a service.

The pharmacy had up to date protocols and patient group directions (PGDs) to support the safe delivery of services. The RP reflected on positive outcomes leading from interventions. For example, working as part of a multi-disciplinary team approach when managing people with co-morbidities. The pharmacy engaged in regular clinical audits. It was partaking in a non-steroidal anti-inflammatory drug (NSAID) audit at the time of inspection. But it did not always provide additional counselling and monitoring checks when supply high-risk medicines to people. The pharmacy had some information relating to the valproate pregnancy prevention programme (VPPP) available. But it had not shared learning relating to VPPP with all members of the team. High-risk warning cards for valproate along with a VPPP information pack was available.

The pharmacy used coloured baskets throughout the dispensing process. This kept medicines with the correct prescription form and helped inform workload priority. Pharmacy team members signed the 'dispensed by' and 'checked by' boxes on medicine labels to form a dispensing audit trail. The pharmacy team kept original prescriptions for medicines owing to people. The team used the prescription throughout the dispensing process when the medicine was later supplied. It maintained delivery audit trails for the prescription delivery service. People signed for receipt of their medicines. The pharmacy maintained an audit trail of people it ordered prescriptions for. This meant it could manage queries and chase missing prescriptions prior to the person attending to collect their medicine. It also used a text messaging service to inform people when their medicine was ready for collection. The trainee medicine counter assistant demonstrated this service and explained people consented to the service.

The pharmacy had a schedule to support workload associated with the multi-compartmental compliance pack service. This allowed the team to manage workload for the service effectively and provided time to chase queries with prescribers when needed. The pharmacy used a module on its computer system to manage the service. The pharmacy recorded changes to medicine regimens and it kept hospital discharge information relating to medicine changes. A sample of assembled packs found the pharmacy did not routinely secure backing sheets to packs. A discussion took place about the need

to ensure the pharmacy attached these sheets securely. Although packs were signed by the pharmacist or ACT as part of the accuracy check, pharmacy team members assembling packs did not always sign them. This meant it could be more difficult to identify who had been involved in the dispensing process. The pharmacy did provide clear descriptions of the medicines inside a pack to help people identify them. And it supplied patient information leaflets at the beginning of each four-week cycle of packs.

The pharmacy sourced medicines from licensed wholesalers and specials manufacturers. Pharmacy team members demonstrated some awareness of the aims of the Falsified Medicines Directive (FMD). A scanner was installed but staff explained they had not received any further details of when processes to comply with FMD would begin. The pharmacy stored Pharmacy (P) medicines behind the medicine counter. This helped to ensure that the pharmacist supervised all sales. The medicine counter assistant was observed bringing the sale of an opioid medicine to the direct attention of the RP. The pharmacy stored medicines in their original packaging in an organised manner. The team followed a date checking rota to help manage stock. Short dated medicines were generally identified through the team circling expiry dates. The team annotated details of opening dates on bottles of liquid medicines. No out-of-date medicines were found during random checks of dispensary stock.

The pharmacy held CDs in secure cabinets. Storage of medicines held inside the cabinets was orderly. There was designated space for storing patient returns, and out-of-date CDs in one cabinet. Assembled CDs were held in clear bags with details of the prescription's expiry date. Pharmacy team members highlighted these prescriptions and could explain the validity requirements of a CD prescription. The pharmacy's fridges were clean and stock inside each fridge was organised well. The pharmacy stored assembled cold-chain medicines in clear bags. This prompted additional checks of these medicines prior to handout. It kept temperature records for both fridges and temperatures recorded were stored between two and eight degrees Celsius as required.

The pharmacy had medical waste bins and CD denaturing kits available to support the team in managing pharmaceutical waste. The pharmacy received drug alerts relevant to the medicines it stocked through email. The pharmacy team checked alerts and kept details of alerts for reference purposes.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy generally has the equipment and facilities it needs to provide its services safely.

Inspector's evidence

Computers were password protected and the team used NHS smart cards which prevented unauthorised access to people's records. Dispensary computers faced into the dispensary and the pharmacy stored assembled bags of medicines within the dispensary, out of direct view of the public area. But some folders in the consultation room held personal identifiable information. A discussion took place about the need to secure the information against unauthorised access. The RP confirmed locking the room between use was possible. Pharmacy team members used a cordless telephone which allowed them to hold telephone conversations in private.

The pharmacy had up-to-date written reference resources and internet access which provided the team with access to clinical information. The pharmacy had some clean, certification marked (CE) measuring cylinders to accurately measure liquid medicines. But it also used some plastic cylinders for measuring methadone, these bore no CE mark. The RP acted to replace the plastic cylinders by sourcing more CE marked cylinders during the inspection. Counting equipment for tablets and capsules was available. The smoking cessation provider periodically calibrated the pharmacy's carbon monoxide machine. All electrical equipment appeared to be in good working order and there were routine safety checks carried out each year. The next check was due in April 2020.

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.