

# Registered pharmacy inspection report

**Pharmacy Name:** Peartree Pharmacy, 110 Peartree Lane, WELWYN GARDEN CITY, Hertfordshire, AL7 3UJ

**Pharmacy reference:** 1114485

**Type of pharmacy:** Community

**Date of inspection:** 02/06/2021

## Pharmacy context

The pharmacy is situated in a surgery building and shares its entrance with the surgery. The pharmacy provides NHS and private dispensing services to local people as well as multi-compartment compliance packs to a lot of people. It is open 100 hours a week and there is a car park opposite the pharmacy. The inspection was undertaken during the Covid-19 pandemic. Due to the pandemic, people are not allowed to enter the pharmacy and instead services are offered through open windows into the pharmacy.

## Overall inspection outcome

### Standards not all 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
<b>1. Governance</b>	Standards met	N/A	N/A	N/A
<b>2. Staff</b>	Standards not all met	2.1	Standard not met	The pharmacy does not make sure that its team members are registered on the required training courses in a timely manner.
<b>3. Premises</b>	Standards met	N/A	N/A	N/A
<b>4. Services, including medicines management</b>	Standards met	N/A	N/A	N/A
<b>5. Equipment and facilities</b>	Standards met	N/A	N/A	N/A

## Principle 1 - Governance ✓ Standards met

### Summary findings

Members of the pharmacy team usually work to professional standards and identify and manage risks effectively. The pharmacy generally keeps its records up to date and these show that it is providing safe services. Its team members understand how they can help to protect the welfare of vulnerable people. And the pharmacy team members keep people's private information safe. They discuss mistakes that happen during the dispensing process with the regular pharmacist. But they do not review the mistakes or discuss them in the wider team. So, the pharmacy may be missing opportunities to find any patterns or trends and learn from these to improve its processes.

### Inspector's evidence

The pharmacy had standard operating procedures (SOPs). The SOPs covered the services that were offered by the pharmacy. A sample of SOPs was chosen at random which were found to have been reviewed in 2018. The written procedures said the team members should log any mistakes they made in the dispensing process in order to learn from them. The pharmacist handed the dispenser any issues that they found and asked them to correct these mistakes. However, they were not discussed within the wider team, nor did the team identify trends and learning from these mistakes. The pharmacy displayed the responsible pharmacist notice in the pharmacy, but it could not be seen by the people using the pharmacy who were on the pavement. The pharmacist said that they would move it to a more conspicuous place. The responsible pharmacist record required by law was up to date and filled in correctly. The pharmacy team members were aware of their roles and they were observed asking the pharmacist for advice when they were unsure of the information to give to people.

An annual survey was usually used to seek people's views on the service provided by the pharmacy, but this had been suspended due to the COVID-19 pandemic. There were generally good online reviews for the pharmacy. The pharmacy had professional indemnity and public liability insurances in place. The pharmacy team recorded private prescriptions and emergency supplies in a book. The controlled drug (CD) registers were up to date and legally compliant. The temperatures of both fridges were recorded daily and showed that the medicines in the fridge had been consistently stored within the recommended range. There were data loggers in the fridges, but this was not used by the regular pharmacist.

The staff had undertaken training about protecting people's private data. Confidential waste was put into a sealed box in the surgery, and the waste was removed by a commercial contractor and destroyed. NHS smart cards were not shared and were stored appropriately when not in use. The staff had also completed the appropriate levels of training about safeguarding vulnerable adults and children and had access to relevant telephone contact numbers for the local safeguarding boards.

## Principle 2 - Staffing Standards not all met

### Summary findings

The pharmacy has enough team members to provide its basic services, but not all the team members start the required training courses in a timely manner. Team members have access to some support for ongoing training to help keep their knowledge and skills up to date.

### Inspector's evidence

At the start of the inspection there was a pharmacist, who regularly worked three days a week in the pharmacy, and a dispenser present. Two more dispensers and a counter assistant arrived later in the inspection. The counter assistant had started working in the pharmacy in August 2019 and had not been put on an accredited course. This should be done within three months of starting in any relevant role, and the requirement for this was highlighted in the report about the last inspection of this premises. There was no evidence of the rest of the staff's qualifications in the pharmacy that the pharmacist was aware of. It was stated that there were two other dispensers and a delivery driver in post. The superintendent pharmacist told the inspector after the inspection that they were trying to recruit another dispenser, but he was finding it hard to get the right candidate.

The staff told the inspector that they did not have any access to training packages, other than the ones for NVQ2 or NVQ3 on which they were enrolled. The pharmacist said that the technician and she could access a continuing training package supplied by a training provider, but that this did not extend to the dispensers and counter assistants. The dispenser confirmed that she had not had any training since she had completed the NVQ2. The superintendent pharmacist said, after the inspection, that the dispensers were also enrolled on a course to provide ongoing training and could access the modules. He added that he did not check how much the staff accessed the information.

There were no targets set for the staff and they reported that the team got on well together and that they could discuss issues as they arose.

## Principle 3 - Premises ✓ Standards met

### Summary findings

The pharmacy's premises are secure and provide an adequate environment to deliver its services. Due to the COVID-19 pandemic, the pharmacy is providing its services to people through the pharmacy's windows. And this is making it harder for the pharmacy to counsel people about their medicines. Some frequently touched parts of the premises may require additional cleaning at this time to reduce the risk of infection transmission.

### Inspector's evidence

The pharmacy was usually accessed through the same doors as the surgery, but this had not been possible since the start of the COVID-19 pandemic. Current access for people using the pharmacy was via opened windows. Prescriptions were taken in through a casement window, where prescriptions were paid for, and sales of pharmacy-only medicines were made. When dispensed prescriptions were ready the person's name was called through another window, which was only able to open at the top, using a small pane. This was not ideal, especially for people who were not very tall, but was the only solution at the time of the inspection.

A cleaner cleaned the pharmacy when there were pharmacy staff present, but the pharmacist was not sure where was cleaned, as she was not present then. It was noted that the windows were cleaned at most once a day, despite being touched by many of the people using the pharmacy. The superintendent pharmacist said, after the inspection, that he would ensure they were cleaned more frequently. There was nowhere for people to easily have a private conversation with the staff, and counselling was not possible through the high window. The pharmacist said she had used the lower window to speak to people, and asked other people waiting on the pavement, in the queue, to stand away from the person receiving care.

The dispensary was clean and bright but very cluttered, with large volumes of orders piled up to be checked off. They were only from the day of the inspection, but while they were there it was difficult to access some of the shelves. The shop area had become a temporary stock room, as had the consultation area which was not currently in use. Multi-compartment compliance packs waiting collection were stored in an area which was quite warm. Monitoring of the temperatures in this area would give reassurance that the storage conditions do not exceed the required temperatures.

## Principle 4 - Services ✓ Standards met

### Summary findings

Overall, the pharmacy delivers its services in a safe and effective manner and it gets its medicines from reputable sources. The current restrictions on access to the premises mean that the pharmacy has limited opportunities for giving verbal advice to people about their medicines. The team tries to make sure that people have all the written information they need so that they can use their medicines safely but there are times when this does not happen. So, this could mean that people do not have all the up-to-date information they need for their medicines. And the pharmacy must make sure that it provides people with all the relevant safety information when it supplies medicines containing valproate.

### Inspector's evidence

People could access the pharmacy's services only via the windows, as described above. The pharmacy only provided dispensing services. The use of baskets helped to ensure that prescription items were kept together and were easy to move from one area of the dispensary to another. It was reported that they sometimes ran out of baskets, which the staff said meant that the SOPs were not followed completely. Computer-generated labels included relevant warnings and were sometimes initialled by the dispenser and checker which allowed an audit trail to be produced. However, signatures of who had dispensed prescriptions were not always present on items dispensed from repeat prescriptions and also multi-compartment compliance packs. These packs had printouts with all the labelling requirements which were so small that it was only just possible to read the warnings. And those with poor sight would not be able to. The printouts were not robustly attached to the packs, meaning that it would be very likely that they would be separated from the packs in the patient's home. No patient information leaflets (PILs) were supplied with multi-compartment compliance packs, meaning that patients could not easily access the information provided by the manufacturer for patients. The SI said that he would address these issues.

The pharmacy had a system of scanning any prescription prior to being handed out. And so, the system would highlight to staff if any prescriptions were no longer valid. Prescriptions for higher-risk medicines such as warfarin, lithium or methotrexate were not flagged. So, this could make it harder for the staff to make sure that people were receiving the advice and monitoring they may need for these medicines. This was true for all types of prescription, whether repeat dispensing, walk-in, deliveries or multi-compartment compliance packs. People in the at-risk group who were receiving prescriptions for valproate were not routinely counselled about pregnancy prevention; the pharmacist said she would do this in future. And appropriate warnings stickers were not available for use if the manufacturer's packaging could not be used. The inspector explained where these could be obtained, and the pharmacist said that she would do so.

The pharmacy got its medicines from licensed wholesalers and stored them on shelves in a tidy way. There were coloured marks on boxes to indicate items which were short dated. Regular date checking was done, and no out-of-date medicines were found on the shelves. Drug alerts were received, actioned and filed appropriately to ensure that recalled medicines did not find their way to people who used the pharmacy.

## Principle 5 - Equipment and facilities ✔ Standards met

### Summary findings

The pharmacy has the right equipment for its services. And it generally makes sure its equipment is safe to use.

### Inspector's evidence

There were various sizes of glass, crown-stamped measures, with separate ones labelled for use with specific liquids, reducing the risk of cross-contamination. The pharmacy had a separate triangle marked for use with methotrexate tablets ensuring that dust from them did not cross contaminate other tablets. The pharmacy had access to up-to-date reference sources. This meant that people could receive information which reflected current practice.

### What do the summary findings for each principle mean?

Finding	Meaning
<span style="color: green;">✔</span> <b>Excellent practice</b>	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.
<span style="color: green;">✔</span> <b>Good practice</b>	The pharmacy performs well against most of the standards and can demonstrate positive outcomes for patients from the way it delivers pharmacy services.
<span style="color: green;">✔</span> <b>Standards met</b>	The pharmacy meets all the standards.
<b>Standards not all met</b>	The pharmacy has not met one or more standards.