General Pharmaceutical Council

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: 24/07/2023

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 supplying medicines in 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.

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	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

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. And they review the mistakes and discuss them in the wider team. So, the pharmacy can find 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. The written procedures said the team members should record any mistakes they made in the dispensing process that were spotted and corrected (near misses) to learn from them. The pharmacist handed the dispenser any mistakes that they found and asked them to correct these. And mistakes were discussed within the wider team so the team could identify trends and learning from these mistakes. Recently, nicorandil and nortriptyline had been separated on the shelves following a near miss.

The pharmacy displayed the responsible pharmacist (RP) notice in the pharmacy. The RP 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.

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 fridges had been consistently stored within the recommended range.

The staff had undertaken training about protecting people's private information. 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 met

Summary findings

The pharmacy has enough team members to provide its services, and they start their required training courses in a timely manner. The pharmacy can provide its team members with ongoing training to help keep their knowledge and skills up to date. But team members are unfamiliar with how to access this training which limits its usefulness.

Inspector's evidence

At the start of the inspection there was a pharmacist, who regularly worked in the pharmacy, a trainee technician, and a trainee counter assistant present. It was stated that there were also a technician, two other dispensers and a delivery driver in post. There were usually two pharmacists present between 1pm and 5pm. 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. But the pharmacist said there was access to a course to provide ongoing training but no one monitored how much of this training was accessed by the staff.

The team had regular access to the superintendent pharmacist and team members said that they could share concerns with them, as needed. There were no targets set for the team members 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 although cramped environment to deliver its services.

Inspector's evidence

The pharmacy premises were modern, large, bright, clean, and organised. The dispensary was small for the volume of prescriptions dispensed by the pharmacy. But the workspace was clutter-free and clean, and each workspace was allocated for certain tasks. A sink was available for preparing medicines. Hand sanitiser was also available for team members to use. Cleaning was carried out by team members in accordance with a rota.

A consultation room was available. The room allowed a conversation at a normal level of volume to take place inside without being overheard. The premises were kept secure from unauthorised access. The room temperature and lighting were adequate for the provision of pharmacy services.

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 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. And information on dispensing labels is sometimes very hard to read. This could mean that people do not have all the up-to-date information they need about their medicines.

Inspector's evidence

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. 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 on multi-compartment compliance packs. These packs had printouts with all the required labelling but the font size was 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 robustly attached to the packs. Patient information leaflets (PILs) were supplied with multi-compartment compliance packs, meaning that patients could easily access the information provided by the manufacturer for patients.

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 always highlighted. So, this could make it harder for the pharmacy to make sure that people were receiving the advice and monitoring they needed 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 routinely counselled about pregnancy prevention.

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 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
✔ 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.