General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Springfield Pharmacy, 24 Springfield Road, Elburton, Plymouth, Devon, PL9 8EN

Pharmacy reference: 9010940

Type of pharmacy: Community

Date of inspection: 12/08/2022

Pharmacy context

This is a community pharmacy located along a parade of shops on a high street in Plymouth. It sells over-the-counter medicines and dispenses NHS and private prescriptions. It is a relatively new pharmacy and provides a range of services including the New Medicine Service (NMS), the Community Pharmacy Consultation Service, the Discharge Medicines Service (DMS), vaccinations, blood pressure checks and a delivery service.

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 largely manages the risks associated with its services. Team members know their responsibilities and what procedures to follow. The pharmacy generally keeps the records it is required to by law. And it has appropriate insurance to cover its services. The pharmacy appropriately protects people's personal information. And team members are aware of how to identify safeguarding concerns and raise these with the pharmacist on duty. The pharmacy does not keep a record of mistakes which happen before medicines are supplied to people. So, team members may be missing out on opportunities to learn.

Inspector's evidence

The pharmacy had a newly appointed Superintendent Pharmacist (SI) at the time of the inspection. The pharmacy had a range of standard operating procedures (SOPs) which were last reviewed in February 2020. But the Superintendent Pharmacist confirmed he had a plan in place to review these over the next three months. The SOPs covered the range of professional services provided by the pharmacy. And pharmacy team members had signed to confirm they had read the SOPs. The SI explained how he observed pharmacy team members when they worked to check they were following the SOPs as they should. And he provided feedback if he identified that the correct procedures were not being followed. The pharmacy did not have documentary evidence of recording record when mistakes happened before the medicine was handed to the people using the pharmacy (so called 'near misses'). But the SI explained the pharmacy separated tasks among team members to reduce the risk of near misses happening. An example of learning from mistakes was when the pharmacy separated the locations of different strengths of sodium valproate tablets (a medicine used for epilepsy) after an incorrect strength was selected when preparing a prescription. The pharmacy had a poster displayed to alert team members to similar sounding medicines such as carbamazepine (a medicine used for epilepsy) and carbimazole (a medicine used to treat an overactive thyroid). There were no risk assessments present at the time of the inspection. But the SI explained during the inspection that he had a plan to complete risk assessments on all services provided by the pharmacy.

There was a Responsible Pharmacist (RP) notice correctly displayed. And there were clear lines of accountability included within SOPs and working practices. Pharmacy team members could explain what their roles and responsibilities were. And the SI explained that the trainee accuracy checking pharmacy technician checked within clear protocols, with the final check for accuracy always being completed by a pharmacist. The pharmacy had a complaints procedure. But pharmacy staff did not actively seek feedback from people using the pharmacy. The SI explained that he identified pharmacy team members who required communication skills training. But the training had not yet taken place. The pharmacy team had regular informal meetings where the SI explained professional aspects of speaking to people using the pharmacy. And explained the importance of listening to people's concerns and to avoid making assumptions.

The pharmacy had indemnity insurance which covered all services provided. And a certificate was displayed in the pharmacy showing this. The pharmacy largely kept the records it was required to. The RP register was generally completed correctly. But there were several instances where the RP did not sign out. This was raised with the SI during the inspection. Records for private prescriptions were available for inspection and these were generally completed correctly. But some records were not

completed with the prescriber's information. The pharmacy kept records of where supplies of a prescription-only medicine were made in an emergency without a prescription. But not all records contained details about the nature of the emergency. Feedback on these aspects was given to the SI during the inspection. Controlled Drugs (CDs) were generally well recorded. CD running balances were checked regularly, and no discrepancies were identified during the inspection. But records for the destruction of CDs returned by people were not always completed promptly. The pharmacy recorded the temperature of the medicines fridge on their electronic record system. But only two days' worth of records were available during the inspection. The SI explained the fridge temperature was checked every day before the pharmacy opens. Records for when the pharmacy supplied unlicenced medicines were largely completed correctly. Some examples with missing details were identified during the inspection, such as details of the person or details of the prescriber. This was highlighted with the SI.

The pharmacy generally protected the confidential information of people who used its services. Pharmacy team members received training on data protection. And confidential waste was disposed of in a separate bin to general waste. The pharmacy had a contract with a third party to remove and destroy confidential waste. Computers were password-protected. And NHS smartcards were observed to be used appropriately by team members to whom they belonged. Patient-identifiable information was not visible from the retail area of the pharmacy.

The pharmacy had a child protection and safeguarding policy. And pharmacy team members had completed safeguarding training. The pharmacy did not have contact details of local safeguarding leads available. But the SI knew the process to raise concerns with the local GP and social services if needed. A delivery driver explained that he kept an eye on vulnerable people who he delivered medicines to. And he knew to raise any concerns with the pharmacist on returning from his delivery route.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough staff to provide its services safely. And team members do the right training for their roles. The pharmacy team works well together. And new team members are supported as they develop in their roles.

Inspector's evidence

During the inspection there were two pharmacists present, one of which held the dual role of RP and SI, and the other was a locum pharmacist. The pharmacists were supported by a pharmacy dispensing assistant, a trainee medicines counter assistant and a pharmacy technician on the day of inspection. The medicines counter assistant had recently joined the team and was enrolled onto a training programme to support their development. And the SI explained that new team members were supported by more experienced team members. The pharmacy technician was training to be an accuracy checker. This would allow them to perform the final accuracy check once the clinical check was completed by the pharmacist. The SI gave assurances that any checking the technician did during their training was always second-checked by a pharmacist before being prepared for collection. The pharmacy dispensing assistant was training to be a pharmacy technician. They were supported by weekly online meetings with their course provider. And they received supervision and support from the pharmacist. The SI said that staff received protected training time to support their development. There were certificates for mandatory training completed by pharmacy team members.

The team appeared to work well together, and the workload seemed manageable. They were preparing medicines against prescriptions received the day before. So, there was no evidence of an excessive backlog, and key tasks were largely completed, indicating there were enough staff for the pharmacy to operate safely. The SI explained that the pharmacy team had regular meetings to discuss a range of work-related aspects. An example was given by the SI of the team discussing drug seeking behaviour. He reinforced the limits placed on certain medicines available to buy over the counter. And what pharmacy team members should do if they thought someone was misusing these medicines.

Pharmacy team members had informal catch-up meetings with the SI, and team members knew how to raise concerns. But the pharmacy did not have a written procedure about how staff could raise concerns, so this could make it harder for them to know how to do this. The SI explained he was planning to conduct appraisals with team members. The SI explained that the pharmacy team did not have any targets. And that all services were provided appropriately based on need rather than financially driven.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are generally well maintained. And the pharmacy is sufficiently clean and secure to provide services safely. It is appropriately secured to prevent unauthorised access. The premises help protect the confidentiality of people who use the pharmacy. But the pharmacy could do more to keep all areas tidy at all times.

Inspector's evidence

The pharmacy was located on a parade of shops along a high street. It had a retail area selling healthcare products, and a pharmacy dispensary at the back where medicines were prepared against prescriptions. The medicines counter had a large clear plastic screen to help with infection control. The pharmacy appeared clean during the inspection. And the SI explained that the pharmacy team cleaned the dispensary and shop at the end of every day. Some medicines ready for collection were stored on the floor. This put them at increased risk of being damaged or dirty. The pharmacy had enough workspace for tasks to be completed at separate locations. And there was a logical workflow which seemed organised. There was a dedicated area for the preparation of medicines requiring dilution and reconstitution.

The consultation room was appropriately signposted and had a notice on the door highlighting it was for consultations. But it was cluttered and used for storage as well as consultation with people. This may have given the impression to people that it was not a suitable place to have a healthcare consultation. The pharmacy was generally well maintained. The lighting was mostly appropriate. But one work bench had an intermittently flickering light above it. The SI agreed to raise this with the maintenance team and have corrected as a matter of urgency. The pharmacy had air conditioning which created a comfortable working environment. And it helped ensure medicines were stored at an appropriate temperature during periods of excessive heat. The pharmacy premises were appropriately secured from unauthorised access.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy is accessible, and it supplies its medicines safely to people. The pharmacy obtains its medicines from licenced suppliers and largely stores its medicines appropriately. It delivers medicines in a safe and appropriate way and maintains records of this. It disposes of its unwanted medicines appropriately and generally keeps appropriate records of this.

Inspector's evidence

The pharmacy had step-free access from the street outside. And pharmacy team members assisted people when required. There was enough room in the pharmacy for people with wheelchairs to manoeuvre. The pharmacy did not advertise what services it provided. But it did signpost people to alternative providers if it didn't provide a service which was asked for. The SI was a member of a local professional communication group where he could ask other pharmacies and GP surgeries what services they provided.

The pharmacy provided multi-compartment compliance packs to people who needed them. And the pack labels contained descriptions of the tablet and capsules inside to help people identify their medicines. The pharmacy had a process to identify changes to medicines in the packs. And discharge summaries were stored on people's records to identify any changes made in hospital. The pharmacy used secure email to communicate with GP practice teams about the packs.

Team members used baskets for each person's prescription. And there were dedicated areas for preparing medicines which was separate to the areas used for checking medicines. This reduced the risk of distractions and mistakes. There was an audit trail for the preparation of medicines so the team could identify who completed each task. An example was team members' initials on dispensing labels for dispensing and checking. The pharmacy team used stickers to highlight when additional advice was needed. Medicines with higher risks associated with their use were managed appropriately. The pharmacy had leaflets to supply along with sodium valproate for people in the at-risk category. And the SI explained what checks were required when supplying this medicine to this cohort of people.

The delivery driver kept a log of deliveries and made notes of any queries or concerns raised when delivering medicines. These were communicated to the pharmacist on returning to the pharmacy. Delivery logs were stored for future reference so the pharmacy team could answer any queries if needed. The delivery drivers knew to contact the pharmacist if they identified any concerns regarding the wellbeing of people they were delivering medicines to. The pharmacy used a dedicated e-referral platform to receive referrals for services such as the Discharge Medicines Service or the Community Pharmacy Consultation Service. The pharmacy team were increasingly storing communications and records for people on the person's personal pharmacy record. This helped team members keep more comprehensive records of the care that people received.

Medicines were obtained from licenced suppliers. And invoices were kept for wholesale deliveries. Medicines awaiting collection were labelled and stored appropriately. The pharmacy had a process to check the expiry dates of medicines held as stock. And every month expiring medicines were removed from shelves and stored in a dedicated area for disposal. No date-expired medicines were identified following random checks during the inspection. Medicines requiring refrigeration were stored in fridges. And the temperatures were checked each day at the beginning of the shift. One fridge used an

internal thermometer, but this had not been reset after each recording. The SI agreed that this would be done in the future.

The pharmacy stored its CDs securely. There were CD disposal kits available. The pharmacy had dedicated disposal bins for medicines. A cytotoxic sharps box was available along with a standard sharps box. Medicines requiring destruction were stored appropriately and segregated from medicines used for dispensing. The pharmacy received alerts about medicines via email. These were assessed by the SI and where action was needed the SI completed this. But there were no records to show what action had been taken and by whom. So, this could make it harder for the pharmacy to show what action had been taken in response to the alerts.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy uses appropriate equipment to provide its services. The pharmacy team have access to resources to help them provide safe and effective services to people. And equipment is used in a way which helps protect the privacy of people using the pharmacy.

Inspector's evidence

The pharmacy had validated measuring equipment for liquid medicines. And these were cleaned appropriately after use. Separate equipment was used when preparing medicines which should be handled separately, such as cytotoxic medicines. Pharmacy team members had access to a range of reference sources to help them support people effectively. The pharmacy had two fridges to store medicines requiring refrigeration. But one of the fridges had food stored alongside medicines. The SI agreed to remove the food. Computer terminal screens were not visible to the public using the pharmacy.

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.