General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Claremont House Pharmacy, 84 Barnards Green Road, Malvern, Worcestershire, WR14 3LZ

Pharmacy reference: 9011270

Type of pharmacy: Community

Date of inspection: 26/07/2024

Pharmacy context

This is a community pharmacy located in the centre of Malvern in Worcestershire. The pharmacy dispenses NHS and private prescriptions. It sells over the counter (OTC) medicines and offers services such as the New Medicines Service (NMS), local deliveries, seasonal flu, and COVID-19 vaccinations as well as Pharmacy First. And the pharmacy supplies people's medicines inside multi-compartment compliance packs if they find it difficult to take them. This includes people in their own homes and residential care 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 overall, has the right systems in place to identify and manage the risks associated with its services. Team members understand their role in protecting the welfare of vulnerable people. The pharmacy has suitable written instructions for staff to follow. And members of the pharmacy team deal with their mistakes responsibly. But they may not have been regularly 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

This was a busy pharmacy; as a result of other pharmacies in the immediate vicinity and county closing, the pharmacy's workload had significantly increased. Whilst some areas for improvement were noted, the team managed the workload well. There were two dispensaries (see Principle 3) and two operations taking place where one involved supplying medicines to care homes and inside multi-compartment compliance packs and the other managed repeat prescriptions as well as walk-in trade (see Principle 4).

The pharmacy had a range of electronic standard operating procedures (SOPs) which provided guidance for the team to carry out their tasks correctly. The SOPs had been read and signed by the staff except for the newest member of the team. At the point of inspection, they had worked at the pharmacy for seven weeks, were being supervised by the manager and their activities involved putting medicines on dispensary shelves after deliveries had been received. After asking a few questions to check their understanding about pharmacy processes, sensible responses were provided. This member of staff had sufficient knowledge about how to protect people's confidential information, what they could or could not do if the responsible pharmacist (RP) did not arrive or was not present and they would refer appropriately. Other staff also knew which activities could take place in the absence of the RP. They had designated tasks and they understood their roles and responsibilities well. However, the inspection took place mid-morning and an incorrect notice to identify the pharmacist responsible for the pharmacy's activities was on display. This was rectified when highlighted by the locum pharmacist.

Once prescriptions had been assembled, the RP usually carried out the final accuracy-check but the accuracy checking technician (ACT) was said to also assist with this. When the ACT undertook this task, the RP clinically checked the prescription first before other staff assembled it. The clinical check was marked on the prescription using a specific stamp. This helped identify that this stage had been completed. Staff confirmed that the ACT was not involved in any other dispensing process other than the final check, and there was an SOP to cover this process.

The workload involved the pharmacy manager downloading electronic prescriptions early in the morning and processing them through the pharmacy's system. The team used baskets to hold prescriptions and medicines during the dispensing process. This helped prevent any inadvertent transfer between them. There was a facility on the dispensing labels to help identify who had been involved in the dispensing process and team members routinely used these as an audit trail.

The team used different coloured baskets when they dispensed medicines for the care homes. Once prescriptions had been processed for the care home(s), each basket contained all the prescriptions

along with a sheet for the care home where staff highlighted any queries at the bottom so they could clearly see if anything was outstanding. There were service level agreements between the pharmacy and the care homes to define the relationship and terms between them. Staff worked on one care home at a time and noticeboards were used to help them visually manage the workload. Both dispensaries were very busy during the inspection and most workspaces were taken up with assembled prescriptions waiting to be checked. This was cleared as the inspection progressed.

The pharmacy had a complaints process and procedures to manage incidents. The RP's process was suitable and in accordance with this. Members of the pharmacy team recorded their own near miss mistakes on an electronic application. The pharmacy's usual and regular RP was said to bring them to the attention of staff so that they could rectify and learn from the situation. The manager said and staff corroborated that the ACT fed back relevant details about them. Neither the regular RP and ACT were present during the inspection and staff present were unsure about whether a collective review took place and no documented details about this were seen. However, the team gave examples of medicines that looked-alike and sounded-alike and the action taken with respect to them, cytotoxic medicines were highlighted, and fast-line medicines separated.

The pharmacy's team members had been trained to protect people's confidential information and to safeguard vulnerable people through relevant and ongoing training. Staff could recognise signs of concern and knew who to refer to in the event of an issue. The RP was trained to level two and contact details for the relevant safeguarding agencies were readily available. The pharmacy's chaperone policy was also on display in the retail area. Confidential material was stored and disposed of appropriately. Computer systems were password protected. However, the inspector noted that a member of staff's NHS smart card had been left within one computer terminal and was being used during the inspection. This person was not on the premises at the time and their password was known. This limits the pharmacy's ability to control access to people's confidential information. In addition, information about the pharmacy's registration with the information commissioner's office which was on display listed out of date details.

The pharmacy's professional indemnity insurance arrangements were valid, and the pharmacy's records were mostly compliant with statutory and best practice requirements. This included records verifying that fridge temperatures had remained within the required range. A sample of registers which were inspected for controlled drugs (CDs). They contained the appropriate details. On randomly selecting CDs held in the cabinet, their quantities matched the stock balances recorded in the corresponding registers. However, the team was using the same register for some CDs for various brands and generic CDs which made it harder to identify which brand (or generic) had been received or supplied. The RP record was mostly complete, but some details of when the pharmacist's responsibility had ceased were missing. Within the electronic register for supplies made against private prescriptions, some details of the prescribers were missing or were seen to be incomplete. Electronic records about the nature of the emergency when a supply of a prescription-only medicine was made, in an emergency without a prescription were also sometimes incomplete. This could make it harder for the pharmacy to justify the supplies made. These points were discussed at the time.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy provides its services using a team with various levels of experience. It supports its team members in their roles. And gives them access to training resources to complete their ongoing training. This helps keep their skills and knowledge up to date.

Inspector's evidence

Staff at the inspection included a locum pharmacist, the pharmacy manager who was a trained dispenser and very experienced, a medicines counter assistant (MCA) and four other dispensers, one of whom was undertaking accredited training for this role. There was also a new member of staff as described under Principle 1 who would eventually work as a dispenser. One of the dispensers was also due to be enrolled onto accredited training to complete the NVQ level 3 in dispensing. Team members had specific roles but could alternate when needed. The workload was said to be manageable when everyone was present, and they covered each other as contingency. Staff wore uniforms and they worked well with each other. This was seen to produce a positive working environment and atmosphere.

Members of the pharmacy team asked people relevant questions when they sold OTC medicines or made recommendations. They were clear on when to seek help and refer to the RP. Team members in training were provided with protected time to complete accredited training. They described being very supported through their training. Staff communicated verbally with regular discussions. They also used an electronic messaging application and had access to training material from an online e-learning resource. Performance reviews took place annually.

Principle 3 - Premises ✔ Standards met

Summary findings

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

Inspector's evidence

The pharmacy premises were professionally presented. The premises included a medium sized retail area, two consultation rooms, two dispensaries, and a spacious back area for storage. Both dispensaries were of an adequate size in comparison to the pharmacy's current volume of workload. More workspace was required but current arrangements meant that staff could still carry out dispensing tasks safely. The pharmacy manager explained that there was potential in the future to extend the premises upstairs. This would create more space for dispensing. The consultation rooms were kept locked when not in use and were appropriate for their intended purpose. The pharmacy was clean. It could have been tidier but most of this was observed to be work in progress. The premises were bright and suitably ventilated. The ambient temperature was suitable for the storage of medicines and the pharmacy was secured against unauthorised access.

Principle 4 - Services ✔ Standards met

Summary findings

Overall, the pharmacy provides its services appropriately and efficiently. The pharmacy sources its medicines from reputable suppliers and stores its medicines suitably. But the pharmacy does not always manage its medicines in the most effective way. The pharmacy has some checks in place to ensure that medicines are not supplied beyond their expiry date. But records to help verify this are missing. And the pharmacy's team members are not always identifying people who receive higher-risk medicines or making the relevant checks. This makes it difficult for them to show that people are provided with appropriate advice when these medicines are supplied.

Inspector's evidence

People could enter the pharmacy from a wide, single, front door, but whilst there was sloped access inside the premises, the pharmacy's front entrance was not level with the outside pavement. This made it harder for someone who used a wheelchair, to enter the building. But the pharmacy team assisted people at the door if needed. The pharmacy's opening hours were on display and five seats were available for people if they wanted to wait. Staff could make suitable adjustments for people with diverse needs. They provided written communication, used simple conversation, information on people's phones and representatives if needed.

People requiring compliance packs had previously been identified as having difficulty in managing their medicines. The pharmacy ordered prescriptions on behalf of people for this service and specific records were kept for this purpose. Any queries were checked with the prescriber and the records were updated accordingly. Staff also routinely obtained hospital discharge summary information to help verify changes. Descriptions of the medicines inside the packs were provided and patient information leaflets (PILs) were routinely supplied. All medicines were removed from their packaging before being placed inside the compliance packs.

The pharmacy supplied medicines to the care homes as original packs but also inside larger compliance packs. Some of the care homes ordered prescriptions for their residents and the pharmacy was provided with copies of the requests. Other care homes relied on the pharmacy to do this. For both, team members checked for any discrepancies or errors and an audit trail about queries was available. The pharmacy provided medication administration records (MARs) which had pictures of residents, and details about allergies as well as sensitivities included. Most of the care homes provided the pharmacy with updates every month. Higher-risk medicines were provided separately but no details about blood test results were asked for or provided. The care homes were supplied with patient information leaflets (PILs), and the team provided descriptions of the medicines. The ACT was said to audit care homes at their request. Staff had not been approached to provide advice regarding covert administration of medicines to care home residents, but some staff, including the RP were aware of the process to take and which relevant guidelines as well as resources to use to assess the suitability of this kind of administration. But they did not obtain relevant information about this situation which was discussed at the time.

The pharmacy offered a delivery service. There were records available to demonstrate when and to whom medicines had been delivered. Failed deliveries were brought back to the pharmacy and three attempts were made by the pharmacy to deliver. No medicines were left unattended.

Staff were aware of the additional guidance when dispensing sodium valproate and the associated Pregnancy Prevention Programme (PPP). They ensured the relevant warning details on the packaging of these medicines were not covered when they placed the dispensing label on them. Relevant checks had been made to identify people who could be at risk that had been supplied this medicine. Appropriate literature was also available to provide to people if needed. However, team members did not routinely identify prescriptions for other higher-risk medicines, they did not ask relevant questions, request specific details about people's treatment from the care homes, or for people supplied compliance packs nor did they record this information.

Once prescriptions had been assembled, checked for accuracy, and bagged, they were stored in a separate section. When people arrived to collect them, they were handed out appropriately. Staff used stickers to identify certain medicines or specific situations. This included fridge lines and Schedule 2 CDs. Counter staff knew that prescriptions for CDs were only valid for 28 days, but they could not identify Schedule 3 or 4 CDs (such as tramadol and pregabalin).

The pharmacy used licensed wholesalers to obtain medicines and medical devices. CDs were stored under safe custody. Dispensed medicines requiring refrigeration and CDs were stored within clear bags which helped easily identify the contents upon hand-out. Medicines returned for disposal, were accepted by staff, and stored within designated containers although the area where they were stored was cluttered. Drug alerts were received electronically and actioned appropriately. Records were kept verifying this. Staff made relevant checks to ensure people who used their services had not been supplied any affected medicine(s), but the care homes were not notified about drug alerts. In addition, team members said that medicines were date-checked for expiry regularly, but appropriate records had not been kept verifying when this had taken place. This made it difficult for them to show that this process had been routinely occurring. However, short-dated medicines were seen to be identified and there were no date-expired medicines seen.

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 is clean.

Inspector's evidence

The pharmacy had access to the necessary equipment and resources in line with its activity. This included internet access, standardised conical measures for liquids, tablet counting triangles and capsule counters. The pharmacy's equipment was clean and fit for purpose. There were also legally compliant CD cabinets and an appropriately operating pharmacy fridge. Portable telephones helped conversations to take place in private if required. The pharmacy's computer terminals were password protected and their screens faced away from people 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.