General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Crowland Pharmacy, 6 West Street, Crowland, Peterborough, Lincolnshire, PE6 0ED

Pharmacy reference: 9011517

Type of pharmacy: Community

Date of inspection: 25/08/2021

Pharmacy context

The pharmacy is in the centre of the historic market town of Crowland, South Lincolnshire. The pharmacy changed ownership in March 2020 and it relocated to its new premises in February 2021. The pharmacy's main services include dispensing NHS prescriptions and selling over-the counter medicines. It delivers some medicines to people's homes. And it is able to arrange for the supply of some medicines in multi-compartment compliance packs, designed to help people to take their medicines. This service is provided via the company's hub pharmacy. The pharmacy was inspected during the COVID-19 pandemic.

Overall inspection outcome

Standards not all met

Required Action: Improvement Action Plan

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Summary of notable practice for each principle

Principle	Principle finding	Exception standard reference	Notable practice	Why
1. Governance	Standards not all met	1.1	Standard not met	The pharmacy does not identify and manage all risks associated with the services it provides. Team members are not aware of any formal procedures relating to the pharmacy's hub and spoke model. And the clinical check of prescriptions dispensed by the hub pharmacy are not recorded.
		1.2	Standard not met	The pharmacy does not encourage its team members to record mistakes made during the dispensing process. And it has no suitable process in place to monitor and act upon the mistakes made to improve patient safety.
		1.6	Standard not met	The pharmacy does not make and maintain all of its records in accordance with legal and regulatory requirements.
2. Staff	Standards not all met	2.2	Standard not met	Not all pharmacy team members in training roles are undertaking the training required for their role. And team members enrolled on training courses are not receiving regular support to help ensure their training progresses smoothly.
		2.5	Standard not met	There is evidence of insufficient action being taken when team members raise legitimate concerns.
3. Premises	Standards met	N/A	N/A	N/A
4. Services, including medicines management	Standards not all met	4.3	Standard not met	The pharmacy does not store medicines requiring refrigeration in appropriate conditions. And it does not have adequate arrangements in place to support the management of medical waste.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance **Standards not all met**

Summary findings

The pharmacy does not adequately identify and manage all the risks with providing its services. It does not use risk assessments and procedures to support significant changes to the way in which it provides its services. And this has led to some confusion in the team about who is responsible for some key processes. The pharmacy also has unrecognised risks relating to information governance. And it does not make and maintain its records as required by law. The pharmacy does not use effective monitoring tools to help engage team members in reporting mistakes made during the dispensing process. This means they miss opportunities to gain experience from mistakes and take action to prevent reoccurrence. Pharmacy team members have appropriate knowledge of the processes in place for managing feedback and for acting to help protect vulnerable people.

Inspector's evidence

The pharmacy had addressed some of the risks of managing its services during the COVID-19 pandemic. For example, it had fitted plastic screens around the medicine counter as part of its infection control measures. Notices on the window advised people not to enter if they were experiencing symptoms and reminded people of the need to wear a face covering in a healthcare environment. But team members were not wearing face coverings at the beginning of the inspection. A brief discussion took place about the most recent NHS guidance requiring people working in healthcare settings, including community pharmacy, to wear appropriate personal protective equipment. And all team members donned a type IIR face mask for the duration of the visit following a request from the inspector.

The pharmacy's dispensary appeared cluttered due to the amount of workspace available. But team members were able to demonstrate an organised and efficient workflow. Team members kept each person's prescription separate throughout the dispensing process by using coloured baskets. And there was enough space for completing labelling and assembly tasks. The responsible pharmacist (RP) had a good amount of protected workspace at the front of the dispensary. This also allowed for adequate supervision of conversations taking place at the medicine counter.

The pharmacy had standard operating procedures (SOPs) to support the safe running of the pharmacy. It stored the SOPs electronically and those presented for inspection had been due for review in January 2021. SOPs covered RP requirements, controlled drug (CD) management and most pharmacy services. But the pharmacy used a hub and spoke model for the supply of medicines in multi-compartment compliance packs. And there was no evidence of SOPs related to this service. Team members confirmed receiving verbal instructions related to how tasks associated with the hub should be completed. The pharmacy kept the original prescription and the hub pharmacy was able to connect to view the prescription. It was not evident whether the hub or spoke pharmacist was responsible for the clinical check of the prescription. The pharmacy team, including the RP thought this task was completed by the hub pharmacist. But a recent GPhC inspection report for the hub pharmacy identified the spoke pharmacist was responsible. There was no evidence of clinical checks being recorded. Team members did identify how they brought changes to the direct attention of the pharmacist prior to prescriptions being made available to the hub pharmacy. A folder said to contain training records associated with the SOPs could not be found during the inspection. A team member who had recently started at the pharmacy confirmed she had read electronic versions of the SOPs and had signed a training record. And pharmacy team members on duty were observed applying vigilance when dispensing medicines. For

example, signing medicine labels to take ownership of their work following a check of the medicine against the label and prescription.

The pharmacy had a formal near miss record. But no entries had been made in this record since the pharmacy had moved premises. The current process for managing a near miss was for the pharmacist to feedback to the team members involved, and team members corrected their own mistakes. There was little evidence of learning from mistakes. And the pharmacy team was not aware of any formal records being made following a dispensing incident. Team members could recall one dispensing incident which had taken place in the new premises. But this had not been resolved following the process described within the SOPs.

The pharmacy had a complaints procedure. And team members were aware of how to manage feedback. And demonstrated actions they had taken in response to some feedback. For example, team members had taken onboard comments from a locum pharmacist in regard to ensuring it held adequate stock of people's regular medicines. The pharmacy had procedures relating to protecting vulnerable people. A team member explained how they would respond to a safeguarding concern. And was aware of how to access up-to-date information if the pharmacy needed to contact a safeguarding agency. The pharmacy held most personal identifiable information in the dispensary. But it held confidential waste in large open sacks within its consultation room. The consultation room was not secured against unauthorised access at the beginning of the inspection. A discussion took place about the risks associated with storing confidential waste in this way, and leaving the consultation room unlocked. The room was secured during the inspection. The pharmacy did have a large industrial shredder and a discussion took place about appropriate arrangements for managing the waste.

The pharmacy had up-to-date indemnity insurance arrangements in place. It maintained running balances in the CD register. But physical balance checks of stock against the register were seen to be sporadic. And the most recent balance check of some CDs on 23 August 2021 had discovered multiple discrepancies. It was not clear how these were being investigated as the regular pharmacist, who had commenced his role in August 2021, had left a note on the front of the CD register listing the discrepancies for the attention of the superintendent pharmacist (SI). Dispensing tokens had been used within the register to highlight what the discrepancies were. And some corrections and foot notes were evident in the register. A phone call with the regular pharmacist following the inspection identified that the investigation was still ongoing. The discrepancies had been reported to a senior pharmacist within the company who was currently on leave. This was due to some confusion within the team about who held the role of superintendent pharmacist. The inspector shared details of how to report unresolved discrepancies to the NHS CD accountable officer and discussed this requirement with the regular pharmacist. Physical balance checks of several CDs did not comply with the balance recorded in the register. And there was evidence of missed entries. The pharmacy did have two red baskets located at the pharmacist's checking station. These were intended to help segregate prescriptions and invoices for entry into the register, but both baskets contained stationary. Records associated with patient returned CDs were mostly in order. But some recently returned CDs required entering into the patient returned CD register.

The RP notice was updated and displayed prominently with the correct details of the RP on duty as the inspection began. The RP register was not kept in accordance with requirements. This was because the pharmacy held both an electronic register and a handwritten register and gaps in both were seen. A discussion took place about the requirement to hold one complete register. Two certificates of conformity associated with the supply of unlicensed medicines were seen to be complete. But these were found on top of a CD cabinet, and were not held in a folder. The pharmacy had a handwritten private prescription register. But not all prescriptions associated with entries made in the register since

the move to the new premises could be found. And a handful of private prescriptions had not been entered into the register.

Principle 2 - Staffing **Standards not all met**

Summary findings

The pharmacy relies heavily on trainee team members to provide its services. And some pharmacy team members are not undergoing training appropriate for their role. This is in contradiction to the GPhC's minimum training requirements for pharmacy support staff. There is little evidence of ongoing support for all team members learning and development due to the lack of supervisory control. The pharmacy does have a policy which promotes how team members can provide feedback. But there is evidence that insufficient action has been taken following team members raising genuine concerns.

Inspector's evidence

On duty on the day of inspection was the RP, who was a locum pharmacist, two dispensers and a delivery driver. The pharmacy also employed an accuracy checking technician (ACT), two trainee dispensers and an additional team member worked on the medicine counter. The ACT was the pharmacy manager and was on long-term planned leave. During the inspection an experienced non-pharmacist manager from another of the company's pharmacies attended the pharmacy. The manager stayed to provide some additional support to the team during the inspection process. Pharmacy team members were not aware of any specific targets in place associated with the pharmacy services provided. And targets had not been discussed with the RP when booking his shift.

The team member working on the medicine counter had been employed for around a year. The pharmacy's delivery driver was also employed after changes to the GPhC's minimum training requirements for pharmacy support staff came into effect in October 2020. The requirements set out the need to enrol all pharmacy support staff on an accredited training course within three months of them commencing their role. There was no evidence of any action taken to support the enrolment of either team member on such a course. One dispenser was working as a trainee pharmacy technician. But was not currently receiving any learning time at work. This meant they had made no recent progress with their course. And the training provider had been in touch to raise a concern relating to this. There was no evidence of training plans or protected learning time provided to team members. And team members did not receive time to complete regular learning associated with the delivery of the pharmacy's services. The pharmacy business changed ownership in March 2020. Pharmacy team members had not yet received an appraisal to help support their ongoing learning and development needs since this transfer of ownership.

The pharmacy did not hold structured staff meetings. But members of the pharmacy team communicated regularly both at work and between shifts. Pharmacy team members were observed working together well and were supportive of each other. For example, taking turns to serve on the medicine counter. The team continually communicated through a secure messaging application. And team members were able to feedback to senior managers and the superintendent pharmacist through the same messaging application. But support following feedback was not always evident. For example, team members had raised a concern about the build-up of medicine waste. The team had been informed to move the waste. But there was no evidence of any action taken to arrange for its collection. Or action to prevent further medicine waste building up in the future. The pharmacy had a whistle blowing policy in place. But team members were not able to identify how they could escalate a concern at work if insufficient action was taken following a team member raising a legitimate concern.

And the owners did not make the company's structure transparent to team members. For example, team members were not aware of who currently held the role of superintendent pharmacist.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are safe and clean. They provide an adequate space for the pharmacy services provided. People using the pharmacy can speak with a member of the pharmacy team in a private consultation room.

Inspector's evidence

The pharmacy was adequately secure and generally clean. But some dust had built-up on lower shelving within the dispensary. The pharmacy had running water and hand washing facilities. The premises consisted of an open plan public area, a private consultation room, a dispensary, and a small office. Lighting was bright throughout the pharmacy and air conditioning ensured the pharmacy stored medicines under 25 degrees Celsius.

The pharmacy had created some additional storage space at the front of the dispensary. It used this space to hold excess stock medicines, and bags of assembled medicines awaiting collection. But some work bench space was also used to store stock medicines. This limited the amount of space available for completing dispensing tasks. But team members had established a good workflow in the space available. Access beyond the medicine counter was deterred though the use of a tape barrier. The pharmacy's private consultation room was accessible via a ramp from the public area. It was a good size and team members were able to socially distance adequately from people when in the room. But the confidential waste bags and some other items stored in the room was not in keeping with a room used for healthcare services.

Principle 4 - Services **Standards not all met**

Summary findings

The pharmacy does not have adequate processes to manage all of its medicines. It does not store medicines requiring refrigeration within appropriate conditions. The pharmacy doesn't have effective arrangements in place to safely manage waste medicines. And it does not protect these medicines from unauthorised access. The pharmacy's services are accessible to people. And pharmacy team members use effective audit trails to help support the management of the pharmacy's general dispensing services.

Inspector's evidence

People accessed the pharmacy through a large pull-door. Team members fed back that some people struggled with the door. The team had requested a bell which would allow people to press for assistance. But this request had not yet been met. The pharmacy advertised its services well through professional looking window displays. And people using the pharmacy had access to some health information leaflets displayed in the public area. Seating in the public area allowed people to wait in comfort. Pharmacy team members were aware of how to signpost a person to another pharmacy or healthcare provider if they required a service or medicine which the pharmacy was not able to provide.

The pharmacy protected Pharmacy (P) medicines from self-selection as it displayed them behind the medicine counter. Team members were involved liaising with the pharmacist appropriately throughout the inspection. And they were observed providing thorough and accurate information about the pharmacy's services when a query arose and when helping a person to choose a medical device for self-testing. Team members explained pharmacists counselled people on the use of their medicines. But there was no specific checks or counselling processes in place for higher risk medicines. Team members demonstrated their understanding of the requirements associated with the valproate pregnancy prevention programme. And the opportunity was taken to promote the correct placement of labels on some valproate packaging following the detachment of the patient card. The pharmacy used clear bags to help prompt additional safety checks of some medicines. For example, cold chain medicines. But it did not have any established processes for ensuring supplies of some schedule 3 and schedule 4 CDs remained legally valid.

The pharmacy team used effective audit trails throughout the dispensing process to help identify who had completed tasks associated with dispensing prescriptions. And some audit trails helped to highlight the availability of stock during the dispensing process. The pharmacy did not routinely undertake tasks associated with the supply of medicines in multi-compartment compliance packs. But did dispense medicines in this way when there was insufficient turn-around time to send them to the hub. The pharmacy's delivery driver completed an audit trail of each delivery made. The pharmacy did not currently require people to sign to confirm delivery of their medicines. The driver posted a card informing people of a missed delivery if they were not at home, and medicines which could not be delivered were returned to the pharmacy. The pharmacy held part-assembled medicines in baskets in a designated area of the dispensary. It held prescription forms associated with these medicines in the baskets alongside the medicines. This ensured the prescription was available throughout the whole dispensing process. The team also retained prescriptions for owed medicines, and dispensed from the prescription when later supplying the owed medicine.

The pharmacy sourced medicines from licensed wholesalers. Medicine storage on shelves was not always orderly which potentially increased the risk of a picking error being made. But the pharmacy did hold medicines in their original packaging. There was no date checking record in place. Team members checked dates routinely during the dispensing process. But it was not clear how often the team completed full date checks of stock and it did not identify short-dated medicines held in stock. A random check of stock found an out-of-date box of ergocalciferol solution for injection. This was segregated from stock and brought to the attention of the team. The pharmacy received medicine alerts and drug recalls by email. Team members checked emails regularly and acted upon these alerts.

The pharmacy had secure arrangements for the storage of CDs. It had two fridges, one pharmaceutical fridge and one domestic fridge. The pharmaceutical fridge was used to hold stock but was not an adequate size for the level of stock currently held. The team had stacked baskets of medicines in the fridge on top of each other. This did not allow for adequate air flow between medicines. The domestic fridge was used inappropriately to hold assembled medicines, beverages and food items. One item of food in a paper bag had been placed on top of a basket containing bags of assembled medicines. The domestic fridge had an ice-box and this required defrosting as a heavy build-up of ice protruded into the fridge. The pharmacy maintained fridge temperature records and these were within the accepted temperature range of 2 and 8 degrees Celsius. But the probe for the thermometer attached to the domestic fridge was not placed appropriately and would not provide an accurate indication of the temperature inside the centre of the fridge, where the assembled medicines were stored.

The pharmacy was holding an excess amount of medical waste. And team members had raised multiple concerns about the storage arrangements for the waste. It was not clear what arrangements if any, the pharmacy had for ensuring the waste was collected regularly through a licensed waste carrier. And it was reported during the inspection that some building contractors had had unsupervised access to the area where the waste was stored.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

Pharmacy team members have access to the equipment they require to provide the pharmacy's services. And they manage and use this equipment in a way which protects people's confidentiality.

Inspector's evidence

The pharmacy had up-to-date written and electronic reference resources available including the British National Formulary (BNF) and BNF for children. Pharmacy team members could access the internet to help resolve queries and to obtain up-to-date information. Computers were password protected, and positioned so information on computer monitors was not visible from the public area. The pharmacy stored bags of assembled medicines in a suitably protected area. This meant people could not read the details on bag labels from the public area of the pharmacy. Members of the pharmacy team used cordless telephone handsets. This allowed them to move to the back of the dispensary or into the consultation room if the phone call required privacy.

The pharmacy had a range of clean equipment available to support the delivery of pharmacy services. It stored counting apparatus for tablets and capsules, and crown stamped measuring cylinders for measuring liquid medicines within the dispensary. There was separate equipment available for counting higher risk medicines to reduce any risk of cross contamination. A blood pressure machine was available within the pharmacy's consultation room. This was used for screening purposes only and was suitably clean and maintained.

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.