General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: St Mary's Pharmacy, 64 St. Marys Street, Ely, Cambridgeshire, CB7 4EY

Pharmacy reference: 9011732

Type of pharmacy: Community

Date of inspection: 17/04/2023

Pharmacy context

This pharmacy is in a purpose-built unit on one of the main streets in Ely. It has some off-street parking and is close to one of the local GP surgeries. Its main activity is dispensing NHS prescriptions, some of which it delivers to people's own homes. And it supplies medicines in multi-compartment compliance packs to some people who need this level of support. The pharmacy is just re-starting an NHS Covid vaccination booster service. And it offers seasonal flu vaccination. The pharmacy also dispenses instalment supplies for substance misuse treatment.

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
1. Governance	Standards not all met	1.6	Standard not met	The pharmacy does not keep all the records it needs to correctly. This includes records about controlled drugs and private prescriptions.
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 not all met	4.3	Standard not met	The pharmacy does not store all its medicines correctly, as required by law.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

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

Summary findings

The pharmacy has some systems in place to identify and manage risks in the pharmacy. These include learning from mistakes and dispensing prescriptions in an organised manner. But the pharmacy does not keep all the records it needs to correctly. And it does not store all its medicines properly. However, members of the pharmacy team work in an organised way. They keep people's information private. And they know when to refer to the pharmacist for advice.

Inspector's evidence

The pharmacy had a set of written standard operating procedures (SOPs) in the pharmacy. Most of these had been prepared in 2017 and the documents indicated they were due for review in 2021. But there was no evidence that a review had taken place. And the signature sheets for the SOPs had only been completed by two or three members of the pharmacy team. The superintendent (SI) explained some of the current staff had transferred from another pharmacy employer and were working to their previous SOPs. He agreed to review the SOPs and make sure all staff were aware of the current procedures to follow when working in this pharmacy. However, dispensing appeared to be carried out generally in an organised manner. There was an audit trail created during the dispensing process to show which members of staff had been involved in dispensing and checking prescriptions. Members of staff involved in dispensing were suitably trained to complete this task. And baskets were used to keep prescriptions for different people separate.

To help identify and manage risks in the dispensing process, the pharmacy kept a record of mistakes that were spotted and rectified before reaching a person. The records were generally made by the pharmacist but the individual member of staff was informed about them so they could reflect and learn from the events. The pharmacy also recorded dispensing mistakes that reached people. When these occurred, the incident was reported to the National Reporting and Learning System (NRLS). A recent incident involved two medicines which sounded similar. The shelf locations for each item had been highlighted to prevent picking errors and the team had been made aware to reduce the risk of the same thing happening again.

When asked, team members could explain the restrictions on the sales of certain medicines which could be misused or over-used, including pseudoephedrine products and painkillers containing codeine, and when to refer queries to the pharmacist. The pharmacy did not sell codeine linctus over the counter.

The pharmacy had current professional indemnity and public liability insurance. The pharmacy clearly displayed a notice showing who was the responsible pharmacist (RP) and this was correct. There was also a record kept about the RP. This record did not always include the time at which the RP finished their shift. Records about private prescriptions were kept electronically but the records did not always contain all the required information. For example, the details of the prescriber were often missing or incorrect. And the entries did not always include the date on the prescription. This information should have been captured at the point of creating dispensing labels for these items. But the SI accepted that staff were not fully aware of the implications of entering wrong or incomplete information when dispensing these prescriptions. Records about unlicensed specials supplied to people were kept but did

not always include details about who had prescribed the medicines.

Controlled drugs (CD) registers were available as were records about patient-returned CDs. However, there were several issues found when these records were reviewed. Some of the entries were very difficult to read and there were multiple amendments due to people making entries in the wrong register or making retrospective entries because of previously missed entries. There were multiple headers missing, increasing the likelihood of entries being made in the wrong register. Balance checks were done infrequently. And one of the balance checks carried out at random during the inspection found a discrepancy between the recorded stock and the physical stock on hand. This could not be resolved during the visit.

Confidential information was protected by the pharmacy and there was an SOP to support this. Confidential waste was separated and disposed of securely. Access to patient records was password protected and people used their own smartcards to access NHS electronic prescriptions. Details on prescriptions could not be seen from the shop floor. And there were private areas of the pharmacy so people could have conversations about their healthcare out of earshot of others in the pharmacy. There were SOPs about safeguarding vulnerable adults and children. And there was some evidence that staff had undertaken the right level of safeguarding training for their roles.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough team members to undertake its work effectively. Its team members have completed or are undertaking the right accredited training for their roles. And they can share important information to help improve the way the pharmacy works. But the pharmacy doesn’t have a current process to assess and address any ongoing learning needs of its team once they have completed their accredited training. So, team members may be missing opportunities to keep their skills and knowledge up to date.

Inspector's evidence

At the time of the inspection, the SI was providing RP cover. There were also at least four dispensers at most times. The SI explained that he was at the pharmacy on most days but there were usually two pharmacists on duty Monday to Friday. It was busy throughout the visit. There had been an IT issue that day which was being resolved and the local surgery had just reopened following a temporary relocation which was increasing the pharmacy’s workload. The pharmacy was also preparing to start an NHS Covid booster vaccination service the following day though some of the equipment was still to arrive for this. Despite these circumstances, the team members appeared to be able to manage their workload.

Team members had completed or were enrolled on the right accredited training for their roles. Some of the dispensers had started additional training to become accuracy checkers. Others had been given similar opportunities but had decided not to proceed as there was little opportunity to study at work. There were some training certificates seen that related to training about Covid vaccinations, health and safety, fire safety, first aid, safeguarding, domestic abuse and safe spaces. Staff also said they tried to keep their knowledge up to date by reading magazine articles. There was currently no formal approach to assessing ongoing training needs or reviewing performance though the SI explained he had informal discussions with team members to check on how they were doing. Team members used a private messaging app to share information with others not present. This included alerting people about dispensing errors to help with the learning process. And they were seen communicating closely and discussing queries with each other during the visit.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy's premises are spacious and present a professional image to people. And the pharmacy has good facilities to provide services to people and maintain their privacy and confidentiality.

Inspector's evidence

The pharmacy had opened in 2021, relocating from much smaller premises close by. It was bright, clean, and spacious. There was some off-street parking just outside the premises, and ramped access to the automatic-opening entrance door, meaning the pharmacy was readily accessible to people with wheelchairs or prams. The shop floor area was large and clutter free and there was ample seating and space for people waiting for services. Two consultation rooms were situated next to one end of the medicines counter. These were well-screened and lockable. And they were kept clean and tidy. Conversations in these rooms could not be overheard from the shop floor.

The dispensary was clearly separated from the shop floor and had ample bench space for dispensing prescriptions and other activities. It was largely clear of clutter though there were several stacks of dispensed and part-dispensed prescriptions waiting to be checked or completed. Different parts of the dispensary were reserved for different dispensing tasks to help workflow. Multi-compartment compliance packs were prepared in a separate room at the back of the dispensary where it was quieter, so distractions did not pose a risk when dispensing these.

Staff had a kitchen and other rest and hygiene facilities. There were separate sinks for handwashing and for preparing medicines. Lighting and ambient temperatures during the inspection were suitable for the activities undertaken and there was air-conditioning available. The pharmacy could be secured against unauthorised access.

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

Summary findings

Generally, the pharmacy supplies medicines safely to people. But it does not always make sure that medicines requiring secure storage are stored correctly. The pharmacy gets its medicines from reputable sources. But it could do more to make sure that date-expired medicines are separated from dispensing stock at an appropriate time. And some people may not always receive all the information they need to take their medicines safely.

Inspector's evidence

The pharmacy's opening hours were displayed at the entrance. There was some health information literature about self-care displayed on the pharmacy counter area. And there was ample seating and space available for people waiting for pharmacy services. The pharmacy delivered medicines to some people who could not visit the pharmacy in person. The pharmacy kept a record of the medicines they delivered.

Baskets were used to keep prescriptions for different people separate. And different coloured baskets were used to prioritise workload. Dispensing benches were allocated to various activities to help manage the workload. There was an audit trail on dispensed items to show who had completed each step of the process from dispensing to accuracy checking. And CD prescriptions were highlighted so checks could be made that the prescription was still valid before being handed out.

The pharmacy supplied medicines in multi-compartment compliance packs to people who lived in their own homes. The dispensers prepared these packs in a separate room at the back of the dispensary to reduce risk. Most people got four weeks of compliance packs at a time. A dispenser explained that descriptions of medicines were only added to the first week due to time constraints. This could mean that, in subsequent weeks, some people or carers are not able to easily identify the contents of their packs. However, patient information leaflets were routinely supplied. Most of the dispensed compliance packs seen were labelled and were sealed. But there were some part-prepared packs found which contained several tablets and capsules but were not labelled and were not sealed. The team members asked could not fully explain why these had been left like this or when they had been prepared. They said this was not in keeping with their usual process. And accepted that this could increase the possibility of contamination with dust or insects and dispensing mistakes. They would avoid this happening in future.

The pharmacy team members understood the safety concerns and advice that needed to be provided to people about valproate-containing medicines. They had recently completed an audit and follow-up activity to make sure anyone they supplied in the at-risk group was fully aware of the need for effective contraception. The team also knew about supplying these medicines in the manufacturer's original container, so people received the right information and alerts. There was no formal process to highlight prescriptions for other higher-risk medicines including methotrexate. So, the pharmacy could not easily show how it made sure that people supplied these medicines were being monitored correctly and were aware of possible symptoms that should be reported. When this was discussed, one of the dispensers said they could start using 'pharmacist' stickers on these prescriptions in future to act as a prompt when handing out these items.

The pharmacy got its medicines from licensed suppliers. Medicines were generally stored tidily on shelves in the dispensary. Waste medicines were stored in designated bins. There was some evidence that medicines with short shelf-lives were highlighted. But, when checked, there were several date-expired medicines found amongst in-date stock that had not been highlighted. The team accepted they were behind on their date-checking routines, but they showed how they had already restarted a full date check of the dispensary. They said they would check dates carefully during the dispensing process to prevent out-of-date medicines reaching people.

Medicines that required refrigerated storage were kept in the pharmacy's three fridges. Maximum and minimum fridge temperatures were monitored and recorded for the fridges and the records seen showed that these had remained within the required range. There was enough storage capacity in the fridges and no evidence of ice build-up.

The pharmacy received safety alerts and recalls about medicines. The team members could explain correctly how these were dealt with and they were aware of and had responded to the recent recall of all medicines containing pholcodine.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide its services safely. And it has systems in place to make sure its equipment is safe to use and works correctly.

Inspector's evidence

The pharmacy had a suitable range of equipment to count and measure medicines. This included counting triangles and validated glass measures. The equipment was clean, and some of it was marked for specific purposes to prevent cross-contamination of medicines. There were cordless phones in the dispensary meaning that staff could move out of earshot of people in the shop area to have private phone conversations. Computer screens containing private information could not be viewed by the public and access to the patient medication records and summary care records was protected by passwords and smartcards. There were processes in place to check that electrical equipment was safe to use.

The pharmacy had sufficient refrigerated storage for the quantity of stock and dispensed items it carried. And the fridges were keeping medicines at the right temperatures. One of the team members leading on the Covid vaccination service could explain the sundries that they needed for this service. They also explained that adrenaline pens were available rather than just adrenaline ampoules and syringes so vaccinators could respond as quickly as possible to anaphylactic reactions.

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.