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:** 08/11/2023

## Pharmacy context

This community pharmacy is located on a main road through Ely. It offers a range of NHS services including dispensing prescriptions and flu vaccinations. It supplies substance misuse treatment to some people. And it delivers medicines to people's homes when they are unable to collect these from the pharmacy. It also supplies medicines in multi-compartment compliance packs to people who need this support to take their medicines at the right time.

## 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

The pharmacy identifies and manages risks to protect the health and wellbeing of people using its services. Its team members have written procedures to tell them how to work safely. And they try to learn from mistakes to reduce the likelihood of similar incidents happening in future. The pharmacy keeps people's information private, and it largely makes the records it needs to. Its team members know when to refer to the pharmacist for advice and their role in protecting more vulnerable people.

### Inspector's evidence

The pharmacy had a set of written standard operating procedures (SOPs) in the pharmacy. These had been reviewed since the last inspection and there was evidence that staff members were re-reading the SOPs. Dispensing appeared to be carried out 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. The superintendent (SI) explained that the pharmacy had introduced a new way of selecting and dispensing medicines so there were additional checks in the process to reduce the risk of mistakes happening. 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 pharmacy had introduced an electronic management system and was starting to keeps records about dispensing mistakes on this system. This would allow for easier reporting and identification of patterns and trends. 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 the supply of the wrong strength of a medicine. The shelf locations for the two strengths had been more clearly separated and the team had been made aware to reduce the risk of the same thing happening again.

The SI explained how the pharmacy had been impacted by the closure of other local pharmacies. It had been approached about providing medicines in multi-compartment compliance packs to more people than it could manage safely. However, it was working closely with another pharmacy to signpost people who wanted this service when needed.

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); this was changed at the start of the inspection to reflect the current RP. There was an electronic record kept about the RP. This record did not include the time at which the RP finished their shift. The RP agreed to review how this record was kept in future. Records about private prescriptions were kept electronically; these had improved

since the previous visit but there were still occasions where the details recorded were not wholly accurate. For example, one entry included information about the wrong prescriber. The RP said this would be reviewed again with the team members. Records about unlicensed specials supplied to people were kept and those checked were complete.

Controlled drugs (CD) registers were available as were records about patient-returned CDs. Following the previous inspection, the pharmacy had started using electronic CD registers and the pharmacists explained this had made keeping these records less time-consuming. Balance checks were now done regularly and when a sample of medicines was checked during the inspection, the recorded balance for each of the medicines agreed with the physical stock. Patient-returned CDs were recorded and there was an audit trail kept of their destruction.

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. Team members were able to explain how they would respond to concerns about vulnerable people.

## 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.

### Inspector's evidence

At the time of the inspection, there were three pharmacists present including the SI. There were also at least four dispensers at most times. It was reasonably busy throughout the visit and the team members were coping with the workload. The SI explained that having at least two pharmacists on duty helped to manage the workload safely and meant the pharmacy could provide a range of additional services to people.

Team members had completed or were enrolled on the right accredited training for their roles. Two new members of staff had started since the previous inspection and were providing cover on Saturdays; they had been enrolled on medicine counter assistant courses. A dispenser had started additional training to become an accuracy checker and there were protocols in place to define the types of prescriptions they could check. And there was a system to identify any prescriptions they had dispensed so these were excluded from their checking workload. 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. Formal reviews were to be introduced in the near future. 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. The pharmacy had weekly catch-up meetings each Friday to discuss updates and issues. Pharmacy professionals said they felt able to exercise their professional judgement when providing services.

## 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 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 clear of clutter and various 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 met

### Summary findings

The pharmacy gets its medicines from reputable sources, and it supplies medicines safely to people. It makes sure medicines are kept in appropriate conditions. And it date checks its medicines regularly to make sure there are suitable to supply to people. The pharmacy can show how it has had a positive impact on the health of people who have used its services, particularly the blood pressure monitoring service it provides.

### 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 and had duplicate records at the pharmacy and with the driver so could handle queries from people promptly.

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. Patient information leaflets were routinely supplied. The pharmacy had introduced improved ways of managing packs that were due to be accuracy checked to prevent the possibility of contamination with dust or insects. Prepared packs seen were labelled and there was a three-way check carried out against the patient record sheet, the current prescription and the prepared packs so any changes could be detected and queried if necessary.

The pharmacy team members understood the safety concerns and advice that needed to be provided to people about valproate-containing medicines. And the recent change that required original pack dispensing and risk assessments if placing in compliance packs. There was no formal process to highlight prescriptions for other higher-risk medicines including methotrexate and lithium. 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, the SI agreed to review how this could be managed more effectively in future. The SI was aware of the national patient safety alert about supplying certain medicines off-label for weight loss purposes.

The pharmacy offered a blood pressure checking service which included the provision of 24-hour ambulatory blood pressure monitors. The SI explained how a pharmacy technician managed this service and how it had led to the detection and treatment of previously undiagnosed high blood pressure in some people.

The pharmacy got its medicines from licensed suppliers. Medicines were stored tidily on shelves in the dispensary. Those medicines requiring secure storage were held appropriately. Waste medicines were stored in designated bins. Since the previous inspection, a robust date-checking process had been introduced and this included keeping a record of the checks made. There were no date-expired medicines found when a number of shelves were spot-checked. Medicines that required refrigerated storage were kept in the pharmacy's four fridges. Maximum and minimum fridge temperatures were monitored and recorded for each of 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 and there were prompts about these on the pharmacy management system that had been introduced recently. The team members could explain correctly how these were dealt with.

## 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 was moving to adopt digital technologies to manage its workload and deliver services more effectively. This included the use of an electronic CD register and app-based ways of recording and monitoring dispensing mistakes. And digital tracking of prescriptions through the dispensing process so people could be informed of when their medicines were ready to collect.

The pharmacy had a suitable range of equipment to count and measure medicines safely and accurately. 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. 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.

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.

## 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. |