General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Letchworth Pharmacy, One Garden City, Broadway, Letchworth, Hertfordshire, SG6 3BF

Pharmacy reference: 9011776

Type of pharmacy: Community

Date of inspection: 19/05/2022

Pharmacy context

The pharmacy is on the edge of the main shopping area of the town. It provides NHS and private prescription dispensing mainly to local residents. The team also dispenses medicines in multi-compartment compliance packs for some people. And it provides treatment and support for people being treated for substance misuse. The pharmacy invests in technology using a dispensing robot and an automated machine allowing 24-hour access to dispensed medicines. It uses an electronic device to monitor its medicine delivery service. People can access an ear wax removal service offered by independent practitioners in the pharmacy consultation rooms.

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

Members of the pharmacy team usually work to professional standards and they mainly identify and manage risks appropriately. They record a few of the mistakes they make during the dispensing process. And they try to learn from these to avoid problems being repeated. The pharmacy generally keeps its records up to date and this help to show that it is providing safe services. Its team members understand how they can help to protect the welfare of vulnerable people. And they keep people's private information safe.

Inspector's evidence

The pharmacy had standard operating procedures (SOPs) which were from the previous premises. The SOPs covered most of the services that the pharmacy offered, but had not been adapted for the new premises. As the working practices had changed significantly a review of the SOPs would ensure the team worked consistently and in the safest way. The services provided in the pharmacy, such as the ear-wax removal, had been risk assessed at the old premises. But these were now out of date and needed to be reviewed. The superintendent pharmacist said he would do this following the inspection, and has told the inspector that this has been completed. The pharmacy planned to have an in-store prescribing service, but were waiting for CQC accreditation before proceeding with the service.

The team members' process was to log any mistakes they made during the dispensing process (near misses) in order to learn from them. They corrected their mistakes. However there were only two near misses recorded since April (6 weeks). Team members said they had made more mistakes in the time, but they had not been recorded, as they were getting used to the new premises. Errors made were discussed within the team, but again they did not record these discussions. They described how they had moved the split boxes of medicines into one alphabetical shelving area as a result of a picking error. The number of picking errors were reported to have been reduced since the move, as there was now a robot in place, but this could not be verified. The use of logs to record and learn from near misses was discussed by the inspector, to improve learning and to spot trends in mistakes.

The pharmacy displayed the responsible pharmacist notice where it could be seen easily. The responsible pharmacist record required by law was up to date and usually filled in correctly. There were a few days where the pharmacist had not signed out at the end of the day. The pharmacy team members were aware of their roles and they were observed asking the pharmacist for advice when they were unsure of the information to give to people. The pharmacy had professional indemnity and public liability insurances in place.

The pharmacy team recorded private prescriptions and emergency supplies on the computer but the details of the prescriber were not always recorded. The controlled drugs registers were up to date and legally compliant. The team checked them every week to ensure that there were no missing entries, there was legal compliance and that the stock levels were as expected. The whole team had had some confidentiality training and were regularly updated with any relevant changes. People accessing the substance misuse service were given regular medication, and the prescriptions were marked at the time of supply with the date as required by law.

Computers and labelling printers were used in the pharmacy. Information produced by this equipment was not visible to people in the retail area. Computers were password protected to prevent

unauthorised access to confidential information. Other patient-identifiable information was kept securely away from the public view. The team were made aware of confidentiality requirements in the staff handbook, which they had all read. The team had also had safeguarding training, and the registrants updated this annually. The pharmacist was aware where to access support, if needed.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough team members to provide its services, using locum dispensers. They work effectively together and support one another. They have the appropriate skills, qualifications and training to deliver services safely and effectively. But the regular use of locums makes the service provision less robust. Team members receive some ongoing training. But this is not very structured. This could make it harder for them to keep their knowledge and skills up to date.

Inspector's evidence

There was a locum pharmacist present when the inspection occurred. He did regular shifts two days a week. The pharmacy team consisted of a pharmacy technician, two dispensers and three counter assistants, who all worked part time in the pharmacy. There were also two more dispensers who were locums, but who worked there regularly. One of the medicine counter staff had been in post since December and was put onto her accredited training course following the inspection. This had been overlooked by the owner. The two locum dispensers were working towards their accuracy checking qualifications. All the other team members had appropriate qualifications for their roles. The superintendent pharmacist had assessed the qualifications of the independent practitioners used on the premises.

Team members wore face masks when out from behind the pharmacy counter and were protected by a plastic screen when behind it. There was hand sanitiser available for use by team members and others using the pharmacy.

The team obviously worked well together, and roles were shared so that in case of absence tasks would get done. Team members were supported by the owner who worked regularly in the pharmacy. Changes to the layout of the pharmacy had been suggested and were being tried. But team members said that they would be happy to say if the changes did not work.

The counter assistants were enrolled on a suitable training course, but the dispensers said that they did not receive any regular ongoing training, except the annual review of confidentiality and safeguarding. They were told about any legislative changes which happened, and had received training about the equipment in the new pharmacy.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy's premises are clean, secure and provide an appropriate environment to deliver its services. People can have a conversation with a team member in a private area. The pharmacy website advertises services which it no longer offers, which may mislead people.

Inspector's evidence

The premises were newly built and large enough for the volume of prescriptions dispensed. The retail area was airy and gave a professional image. The counter had plastic screens to act as a barrier between the public and the staff to help to reduce the spread of COVID-19. There was hand sanitiser available for use by the customers. The dispensary was divided into separate areas for dispensing walk in and urgent prescriptions, repeat dispensing, multi-compartment compliance pack dispensing and checking. There was adequate storage for dispensed prescriptions to be easily found.

The pharmacy website was not up to date. It contained information about services which were no longer offered. The pharmacy had a new website in production, but it was not yet live.

Principle 4 - Services ✔ Standards met

Summary findings

Overall, the pharmacy delivers its services in a safe and effective manner and it gets its medicines from reputable sources. Pharmacy team members are helpful and give advice to people about where they can access other support. They try to make sure people have all the information they need so that they can use their medicines safely although there are times when this does not happen consistently.

Inspector's evidence

The pharmacy was accessed via automatic doors which had a ramp from pavement level. Services were advertised in the windows and on its website. The two 24-hour dispensed prescription collection units were located at the side of the pharmacy building and allowed people to access their medicines when the pharmacy was closed. The units were different colours and the person due to collect would be automatically sent a text when their medicine was loaded into the unit. They would be directed to the specific colour unit containing their medicine. If the person had to pay for the items, then one of the units took card payments, either contactless or using a PIN. The unit sent an automatic text to the person when their prescription was loaded into the machine. This created a unique code which was used to access the person's prescription. Only medicines which did not need specific counselling were put into the units. And no controlled drugs or bulky items.

There was a dispensing robot with an automatic loading module used to pick items for dispensing. Medicine expiries were checked before loading, and anything with less than 6 month's expiry was returned to the wholesaler. Bulky items were stored on dispensary shelves. Any split boxes were also stored on dedicated shelves, and all the staff checked this area before selecting products from the robot if smaller than whole packs were required for the prescription. Small items, such as eye drops, were loaded into the robot on a separate loading bay, as the automated system could not cope with them.

Computer-generated labels for dispensed medicines included relevant warnings and were initialled by the dispenser and checker which allowed an audit trail to be produced. The team members used baskets when dispensing to help ensure that prescription items were kept together and were easy to move from one area of the dispensary to another. When labels were generated, the medicines were supplied from the robot, and then the labels were attached onto the medicine packaging by the team. The process had changed since moving to the new shop, in that each person dispensing was responsible for the process from labelling until the accuracy check. There were plans for this to be done by the dispensers, who were undertaking accuracy checking courses, so that the pharmacist's time could be spent in counselling patients. There is a risk that although the dispensers were being trained, as they were not employed, the solution was not future-proofed.

Prescriptions for warfarin, lithium or methotrexate were not flagged so team members did not know to ask about any recent blood tests or the person's current dose. So, there was some risk that the pharmacy wasn't always able to monitor these people in accordance with good practice. this included people taking higher-risk medicines who had their medicine delivered, or collected from the 24-hour automated machine, or in multi-compartment compliance packs. This was discussed. Schedule 4 controlled drug prescriptions were not always highlighted to the team members who were to hand them out. This increased the chance of these items being given out after the 28 day expiry date on the

prescription. People in the at-risk group who were receiving prescriptions for valproate were usually counselled about pregnancy prevention, although this was not a robust process. Appropriate warnings stickers were available for use if the manufacturer's packaging could not be used. Following discussion with the pharmacist, the team decided that they would use the stickers available to them at the dispensing stage, so that it was more likely that these high-risk medicines would be flagged and people counselled.

Some people were being supplied with their medicines in multi-compartment compliance packs. These packs were labelled with the information the person needed to take their medicines in the correct way. The packs also had tablet descriptions to identify the individual medicines contained in the packs. Patient information leaflets (PILs) were supplied, meaning that people could easily access the information provided by the manufacturer about their medicines. There was a summary sheet in the pharmacy for each person receiving these packs showing any changes to their medicines and where the medicines were to be placed in the packs. There were two members of the team who regularly dispensed the packs, so that if one was off work there was a contingency plan.

The superintendent pharmacist offered a "Prolongevity" service, where people were given advice to reduce their risk of future illnesses. The pharmacist worked with the people's doctor to de-prescribe. These consultations were usually by an on-line platform but could be face-to-face. Appointments were booked through the website.

The pharmacy got its medicines from licensed wholesalers and stored them on shelves and in the robot in a tidy way. There were coloured dots on the shelves and boxes to indicate items which were short dated. Regular date checking was done and no out-of-date medicines were found on the shelves. Any medicines in the robot were given a nominal 6 month expiry and these would be rejected from the robot to allow for regular expiry date checks. The team returned the medicines to the robot if they were still in date. The fridge temperatures recorded showed that the medicines in the fridge had been consistently stored within the recommended range. Drug alerts were received and actioned appropriately to ensure that recalled medicines did not find their way to people who used the pharmacy. And the pharmacy could demonstrate they had responded to these alerts.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy generally has the right equipment for its services. It makes sure its equipment is safe to use.

Inspector's evidence

There were various sizes of glass, crown-stamped measures, with separate ones labelled for specific use, reducing the risk of cross-contamination. The pharmacy had a separate triangle marked for use with methotrexate tablets ensuring that dust from them did not cross contaminate other tablets. Electrical equipment was regularly tested. Stickers were affixed to various electronic equipment and displayed the next date of testing. The pharmacy had access to up-to-date reference sources. This meant that people could receive information which reflected current practice.

The robot was able to be used manually if there was a power cut, although it would be a slow process. This and the 24-hour units were covered by a maintenance programme with urgent breakdown care.

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.