

Registered pharmacy inspection report

Pharmacy Name: Pickfords Pharmacy, 19-21 Norwich Road,
Leicester, Leicestershire, LE4 0LR

Pharmacy reference: 9012284

Type of pharmacy: Community

Date of inspection: 09/04/2024

Pharmacy context

The pharmacy is in a row of shops in a residential area. It provides NHS services such as dispensing prescriptions, the New Medicine Service, the Pharmacy First service, Contraception service, COVID and flu vaccinations. It also offers a prescription delivery service. The pharmacy supplies medicines in multi-compartment compliance packs to people who need this support; these are predominantly prepared by a central dispensing hub.

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 mainly identifies and manages risks to ensure its services are delivered safely. It has procedures in place to help achieve this. And the pharmacy keeps the records it needs to by law. Team members have the relevant training to protect the welfare of vulnerable people. The pharmacy has some procedures to learn from its mistakes. But because the pharmacy team members do not record all their mistakes, the pharmacy might miss opportunities to improve its ways of working.

Inspector's evidence

The responsible pharmacist (RP) sign was correct and visible to the public at the time of inspection. The pharmacy had new standard operating procedures (SOPs) which had been recently received from the pharmacy's head office. The branch manager was in the process of getting staff to read and sign the updated SOPs. Team members asked were clear about their roles within the pharmacy environment, knew when to refer to the pharmacist, and what to do if a pharmacist was absent. They were seen dispensing medicines safely. The accuracy checking pharmacy technician (ACPT) knew that she could only complete an accuracy check of a prescription after the pharmacist had completed a clinical check. The pharmacist signed the prescription to show that he had done this. Staff knew the correct questions to ask to sell medicines safely and were aware of medicines with the potential for abuse.

The pharmacy had processes for learning from dispensing mistakes that were identified before reaching a person (near misses) and dispensing mistakes which had reached the person (errors). The pharmacist said that he would discuss dispensing mistakes with individuals at the time a near miss was made, to raise awareness. Some look-alike, sound-alike medicines were separated on the shelves, demonstrating learning from a previous error. Team members were aware of how to report a dispensing error and who to refer to. The aim was to record all near misses in the near miss log, but team members said that they did not always record them. Therefore, opportunities to identify trends and increase the safety of services may be missed. The branch manager gave assurances that they would record near misses in the future.

The pharmacy encouraged feedback from the public about its services. People could give feedback by Google reviews and by other ways such as in person or online. Feedback could be escalated to head office where necessary. The branch manager said that they would use the consultation room for any private discussions with people and there was a complaints procedure for staff to follow.

RP records were held electronically and were mostly complete. The controlled drugs (CDs) register was on an electronic system which was clear and well maintained. As per the pharmacy's SOP a weekly balance check of CDs was performed and a random balance check during the inspection of one of the medicines tallied with the stock present in the cupboard. Team members were aware of the relevant checks to perform when handing out these medicines to the public. CDs awaiting destruction were separated from the stock and medicines awaiting collection. Patient-returned CDs were recorded in a designated register.

The branch manager said that people requesting emergency supplies were directed to their GP practice or NHS 111 for a prescription. For referrals from NHS 111 a note was made on the electronic patient's medication record (PMR) to ensure that the pharmacy had an audit trail for these types of supplies. The

prescriber was not always recorded for records about private prescriptions. And although the documentation for unlicensed medicines were filed on site, staff rarely recorded the details about the person who received the medicine and the prescriber. The branch manager said they would ensure this was done in the future.

Access to the PMR was password protected meaning that confidential electronic information was stored securely. Confidential paper waste was destroyed appropriately. But some patient-returned medicines that were ready to be sent for destruction still had patient details visible. The branch manager thought there was a confidentiality agreement with the waste contractor so that patient details no longer needed to be hidden. But they said that they would hide patient details until this was confirmed. The superintendent subsequently confirmed that the pharmacy was now hiding any patient identifiable information on waste medicines. The General Data Protection Regulation (GDPR) policy was displayed in the retail area.

Professional indemnity insurance was in place. The pharmacy team members understood safeguarding requirements and could explain the actions they would take to safeguard a vulnerable person. The pharmacist had completed level 4 safeguarding, and each member of the team completed a mandatory annual refresher training about safeguarding. The pharmacy team members were aware of the 'Safe Space Initiative,' and they knew what to do if someone 'asked for Ani'.

Principle 2 - Staffing ✓ Standards met

Summary findings

The pharmacy has adequate levels of staff for the services it provides. And it supports the development of its team. Team members can raise concerns if needed. And their ability to make professional decisions is not impeded by targets. The pharmacy's head office is able to offer support where necessary to ensure patient safety is maintained.

Inspector's evidence

The branch manager was an ACPT and they managed the staffing of the pharmacy. The pharmacy did not have an employed pharmacist and relied on regular locum pharmacists for cover. The team members reported that they were able to contact head office for support if they were struggling for staffing or if a pharmacist didn't turn up at the start of the day.

During the inspection, the pharmacy team managed the day-to-day workload of the pharmacy effectively. The staff had recently completed training for antibiotic medicines and waste management, the dispenser said she also read online forums to keep up to date with healthcare news. Team members had the opportunity to develop and expand their roles, for example the ACPT had completed vaccination training and had been able to participate in offering this service under the national protocol. When asked, a trainee counter assistant said she felt supported by the team. The pharmacist had completed the training they needed to provide the new 'Pharmacy First' NHS service. Team members felt comfortable in raising concerns and had an annual appraisal with the branch manager to identify areas for development.

There was one counter assistant employed in October 2023 awaiting registration for training. The branch manager was aware that this employee should be undertaking a recognised training course within 3 months of being employed and said she would chase head office for this. The superintendent subsequently confirmed after the inspection that the counter assistant had been registered on a recognised course. All other staff members were undertaking training courses or were already qualified.

The pharmacy's head office issued targets for services and monitored these each month. If these targets were not met a call was organised with the branch manager to discuss the reasons and offer support. The branch manager could provide examples of how support was given to ensure patient safety was upheld. The pharmacist felt he was able to make professional decisions and felt that the targets did not impede this.

Principle 3 - Premises ✓ Standards met

Summary findings

The pharmacy is clean and tidy, with adequate space to provide its services safely. It keeps its premises safe, secure, and appropriately maintained. And people visiting the pharmacy can have a conversation with a team member in private.

Inspector's evidence

The pharmacy had a spacious retail area with some seating for people waiting for a service. Pharmacy only medicines were kept behind the counter and there was a belt barrier to restrict access to the dispensary. The pharmacy had two consultation rooms, but at the time of inspection one of the consultation rooms was used for storage. The branch manager explained that the second room was used for Covid and flu vaccinations when they had active NHS contracts for these services. There was some patient information in folders left unattended in the frequently-used consultation room; these were moved during the inspection.

The premises were clean, generally tidy and were well-lit. There was air conditioning to maintain a suitable temperature for storing medicines. There were multiple hand washing facilities available in dispensary, staff room and consultation rooms. Unauthorised access to the pharmacy was prevented during working hours and when closed.

Principle 4 - Services ✓ Standards met

Summary findings

The pharmacy offers a range of healthcare services which are accessible to people. It manages its services and supplies medicines safely. The pharmacy obtains its medicines from licenced suppliers and stores these medicines appropriately, so they are safe to use.

Inspector's evidence

The pharmacy had step-free access through an automatic door which provided good access for people with a disability or a pushchair to get into the pharmacy. A hearing loop was available if required. Large-print labels were available on request.

All medicines were sourced from reputable suppliers. A random spot check of stock revealed no expired medicines and a date checking matrix was used to ensure stock was regularly checked for out-of-date medicines. Coloured dot stickers were used to highlight short-dated items on the shelves. Medicines were stored in their original containers and opening dates were written on bottles of liquids so that the team would know if they were still suitable to use. CDs were stored appropriately. MHRA recalls and alerts were received through the branch manager's email, the pharmacy's general email, and pharmacy computer system. The branch manager said that they actioned these immediately but no longer printed and signed them to create an audit trail. The branch manager said they would make sure that evidence of actions would be recorded in the future.

The pharmacy used a dispensing audit trail which included use of 'dispensed by' and 'checked by' boxes on the medicine labels to help identify who had done each task. Baskets were used to keep medicines and prescriptions for different people separate to reduce the risk of error.

The pharmacy supplied medicines in multi-compartment compliance packs to people living in the community to help them take their medicines at the right time. Multi-compartment compliance packs were dispensed at a central company hub with only a few electronic compliance devices dispensed on site. Compliance packs seen included medicine descriptions on the packs to make it easier for people to identify individual medicines in their packs. But no patient information leaflets (PILs) were present with those packs ready to supply. The branch manager said she would raise this with the hub. Charts documenting medicines information relevant to each person were untidy, with some information such as medicines crossed through. The branch manager said that they were in the process of updating charts to make them clearer to interpret.

The pharmacy operated a delivery service and drivers obtained an electronic signature from each person. For deliveries containing CDs, people were asked to sign a second box for confirmation of receipt. Any uncollected prescriptions were removed from the shelf after contacting the person, two months after dispensing. Stickers were available to highlight shorter-dated CD prescriptions to prevent these medicines being supplied when the prescription was no longer valid.

The pharmacy was providing the 'NHS Pharmacy First' service. This allowed the pharmacy to treat seven common conditions including supplying prescription-only medicines. All accompanying patient group directions (PGDs) were valid and signed and, the pharmacist had completed all relevant training for these. The pharmacy had positive experience from offering the services.

The pharmacist said that he requested to speak to people if there were any potential interactions with their medicines and the ACPT said that they also counselled people taking any high-risk medicines. The pharmacy team members did not routinely record the latest blood test results on the person's PMR but ensured that they were verbally checking that the person was aware when their next test was due. The ACPT was aware of the latest sodium valproate guidance and said that they only supplied full packs of valproate-containing medicines. The pharmacy did not dispense valproate in multi-compartment compliance packs; these were dispensed in original packs separately for people. The pharmacy had completed audits for high-risk medicines, an anticoagulant audit and audits about antimicrobial stewardship and infection prevention and control. Staff had undertaken recent antimicrobial training refreshers.

Principle 5 - Equipment and facilities ✓ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs for the services it provides. It maintains its equipment so that it is safe to use.

Inspector's evidence

The pharmacist and ACPT said that they used up-to-date information resources such as the British National Formulary for clinical checks and providing advice to people. The pharmacy used suitable measures for measuring liquids and had separate ones for certain substances that were clearly labelled. Clean triangle tablet counters were available for dispensing and a new otoscope was available for providing the Pharmacy First service. There was a new blood pressure monitor in the consultation room and 24-hour ambulatory blood pressure monitors were available to request via the company's head office if required. Devices in the pharmacy had portable appliance testing stickers showing a next due date of August 2024.

There was one pharmaceutical fridge in the dispensary and its operating temperature was within the required range of between 2 and 8 degrees Celsius at the time of inspection. Records showed that it kept medicines consistently within the required range. Some medicines were pushed to the back of the fridge which increased the risk of them freezing. The pharmacist said that the stock would be reorganised to address this.

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.