General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: WELL, Deepings Health Centre, Godsey Lane, Market Deeping, PETERBOROUGH, Cambridgeshire, PE6 8DD

Pharmacy reference: 1029309

Type of pharmacy: Community

Date of inspection: 24/05/2023

Pharmacy context

This pharmacy is situated alongside a GP surgery in the rural Lincolnshire town of Market Deeping. Its main services include dispensing NHS prescriptions and selling over-the-counter medicines. The pharmacy supplies some medicines in multi-compartment compliance packs, designed to help people remember to take their medicines. And it offers a medicine delivery service to people's homes.

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

The pharmacy generally identifies and manages the risks associated with its services appropriately. It keeps people's confidential information secure, and it mostly keeps the records it must by law. Pharmacy team members know how to respond to feedback they receive from people using the pharmacy. And they understand their role in recognising and reporting safeguarding concerns. They engage in some shared learning to help reduce risk following mistakes made during the dispensing process.

Inspector's evidence

The pharmacy had standard operating procedures (SOPs) to support its safe and effective running. These covered responsible pharmacist (RP) requirements, controlled drug (CD) management, dispensary processes and pharmacy services. The pharmacy held the SOPs electronically and its superintendent pharmacist's team reviewed them on a rolling two-year rota. A sample of training records confirmed team members had completed learning associated with the SOPs. And they discussed recent learning they had undertaken about data protection and some updated SOPs. Pharmacy team members understood their own roles and responsibilities and referred to the RP for support when required. For example, when confirming that a prescription for a CD did not meet legal requirements as it contained no directions.

Pharmacy team members generally recorded the mistakes they made and identified during the dispensing process, known as near misses. They used an electronic reporting tool to do this. But team members felt there were some challenges associated with making these records at times as they explained they did not always receive feedback about their mistakes from locum pharmacists. Reporting also declined during periods of heightened workload pressure. For example, ahead of bank holidays. The RP on duty, who was the regular pharmacist, encouraged reporting and worked with team members to address near misses and promote learning from them. For example, by asking team members to check their work again to help them identify their own mistake. The team used the electronic reporting tool routinely to record mistakes that were made and identified following the supply of a medicine to a person, known as dispensing incidents. And they demonstrated how they shared learning of these types of events and acted to reduce risk of a similar mistake occurring. The reporting tool had a dashboard feature that supported the team in identifying trends in mistakes, but this feature was not working during the inspection. This meant it was not possible to review any recent learnings applied during the team's regular safety discussions.

The pharmacy advertised details of its complaint's procedure within its public area. A team member explained how they would manage a concern with a focus on local resolution whenever possible. And they were aware of how to provide details to people of how they could escalate their concern in the event it could not be resolved at a local level. Pharmacy team members understood the importance of safeguarding vulnerable people. They completed mandatory safeguarding learning and the team had immediate access to procedures and contact information to support them in reporting these types of concerns. Team members knew what to do if somebody attended the pharmacy and either asked to use the pharmacy's safe space or asked to speak with 'ANI,' a codeword used to alert pharmacy team members that somebody experiencing domestic abuse required assistance.

The pharmacy displayed a privacy notice. This informed people how it managed and used their information. It stored personal identifiable information in staff-only areas of the premises. Team members used the confidential waste bin and bags provided to dispose of confidential waste securely. A secure shredding service discarded of this waste periodically. The pharmacy had up-to-date indemnity insurance. The RP notice displayed contained the correct details of the RP on duty. And its RP record was generally compliant, one missed sign-out time was seen on the sample of the register examined. The pharmacy kept its up-to-date prescription only medicine (POM) register electronically through a reporting function on its patient medication record (PMR) system. But some records did not include details of the prescriber as required. This identified a training need which the RP and a dispenser were keen to explore. The company's SOP stated that private prescriptions should be written into a physical POM register, but the team did not keep this record up to date. This meant that although it maintained a legal record as required by law, it was not following its own SOPs. The pharmacy held its CD register electronically. Records conformed to legal requirements. The pharmacy checked physical stock levels against the balances recorded in the CD register most weeks. It held a record of patient returned CDs within the electronic register and this was maintained to date.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has a team of suitably skilled and knowledgeable people working to provide its services. Pharmacy team members work together well, and they engage in regular learning relevant to their role. They understand how to raise concerns at work. And they participate in ongoing discussions relating to patient safety and risk management.

Inspector's evidence

The RP worked as the regular pharmacist three days a week; they were a member of the wider relief team. Locum pharmacists covered shifts across the remaining two days. The pharmacy employed three part-time and two full-time qualified dispensers and a delivery driver. One dispenser held the role of team leader and was on annual leave on the day of inspection. Part-time members of the team were working additional hours across the working week due to this absence. Team members felt there had been periods of heightened workload pressure coming out of the pandemic. For example, the team reported dispensing more prescriptions locally due to rejections from the company's hub pharmacy thought to be caused by stock availability issues. And it had experienced heightened workload pressure during a period where the local surgery had switched to a new clinical record system. This had occasionally led to the delay in completing some tasks as the team's focus was on ensuring it provided an efficient dispensing service during its busier periods. Pharmacy team members worked together well, and they felt able to feedback concerns at work. A team member explained how they would do this and was aware of how to escalate a concern if required. Team members had access to an employee assistance programme, and the pharmacy advertised how team members could access this service.

Pharmacy team members completed regular learning associated with their roles. Most team members completed this learning at home. This was not an expectation, and they were able to take time at work if they preferred. They were supported through a structured appraisal process that reviewed their learning and development objectives. Pharmacy team members engaged in regular conversations and group discussions about workload management, patient safety and progress associated with the pharmacy's targets. Team members felt confident in sharing their ideas to support the safe management of work. For example, a team member had shared how their previous employer had managed workload associated with the substance misuse service. And the pharmacy had adapted how it managed tasks associated with this service as a result of this feedback. The RP felt able to apply their professional judgement when delivering the pharmacy's services. They discussed how they managed dispensary workload around other face-to-face consultation services.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are appropriately maintained and secure. They provide a suitable space for the delivery of healthcare services. People using the pharmacy are given the opportunity to speak with a member of the pharmacy team in a private consultation room.

Inspector's evidence

The pharmacy was secure and maintained to an appropriate standard. It was generally clean and organised throughout, with some minor attention required to floor spaces where areas of dust and debris had gathered. The pharmacy was air conditioned and lighting throughout the premises was bright. Pharmacy team members had access to sinks equipped with antibacterial hand wash and paper towels. And hand sanitiser stations were available throughout the pharmacy.

The public area was open plan, the pharmacy’s consultation room was accessed off this area. It was clearly advertised and offered a good-sized private space for holding confidential discussions with people. Team members were observed asking people if they wished to speak in private when they attended to seek advice from the pharmacist. The dispensary offered appropriate space for the level of dispensing activities seen. Workflow was managed well, and team members explained how this was adapted during busier periods to help manage the volume of prescriptions received. The RP had protected space at the front of the dispensary and the team used a work bench at the back of the dispensary to complete tasks associated with the multi-compartment compliance pack service. Access to staff kitchen and toilet facilities led off the dispensary.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's services are accessible to people. It obtains its medicines from reputable sources, and it mostly stores and manages its medicines appropriately. Pharmacy team members engage well with people accessing the pharmacy. They provide relevant information when supplying medicines. And they work well with other healthcare professionals to support people's healthcare needs.

Inspector's evidence

People accessed the pharmacy through a manual door from the onsite carpark. The pharmacy displayed its opening times and details of the services it provided. It had a range of health information leaflets and posters within its designated waiting area. It had chairs available in this area for people waiting for their medicine or a service. Pharmacy team members were observed signposting people to other healthcare providers when necessary. And they were empathetic to people's personal circumstances by taking the time to understand their situation and healthcare needs. For example, during the inspection they worked quickly and professionally to bring a matter to the surgery's attention on behalf of a person who required urgent medication. The RP reflected on beneficial outcomes for people accessing the pharmacy's services. For example, the pharmacy had identified a number of people with previously undiagnosed hypertension that had gone on to receive prescription medicines and lifestyle advice to support them in managing their health.

The pharmacy protected Pharmacy (P) medicines from self-selection by displaying these behind the medicine counter. The RP was able to supervise the activity taking place in the public area from the dispensary. The pharmacy held assembled cold-chain medicines and CDs in clear bags. This informed additional safety checks when handing out these medicines. The RP provided verbal counselling associated with the ongoing monitoring of higher-risk medicines. But the team did not routinely record these types of interventions to support continual care. The pharmacy had the necessary support tools to comply with the valproate Pregnancy Prevention Programme (PPP). The team understood the requirements of the PPP and the RP was aware of additional counselling and checks required when supplying valproate to a person within the at-risk group.

Pharmacy team members used coloured baskets throughout the dispensing process. This effectively kept medicines with the correct prescription form. It also supported the team in managing the pharmacy's offsite dispensing service effectively. For example, the team used different coloured baskets to identify locally dispensed prescriptions, prescriptions sent to the offsite hub pharmacy and prescriptions part-assembled locally and part-assembled by the hub. The pharmacy's processes associated with this service ensured a pharmacist completed data accuracy and clinical checks of prescriptions prior to transmitting data to the hub pharmacy. The team used handheld devices with barcode technology to support it in matching bags of assembled medicines with prescription forms and storing them safely in the retrieval area or processing them for delivery to people's homes.

Pharmacy team members routinely signed the 'dispensed by' and 'checked by' boxes on medicine labels to form a dispensing audit trail. The pharmacy had a system for managing the medicines it could not supply immediately, known as owings. And the team worked efficiently to dispense owed medicines and to monitor stock supply issues. It regularly shared information about supply issues with the

neighbouring GP surgery. And it worked well with the dispensary team within the GP surgery to support access to medicines. The pharmacy had an electronic audit trail of the medicines it delivered to people's homes and a list of deliveries for each day remained in the pharmacy. This supported the team in answering any queries relating to the service.

Two dispensers completed regular tasks associated with the supply of medicines in multi-compartment compliance packs. Other team members could support the service if needed and a schedule helped to ensure the team completed tasks associated with the service in a timely manner. The pharmacy used individual profile sheets to record details of people's medicine regimens. And these generally included detailed information of medication changes. A sample of assembled compliance packs contained full dispensing audit trails and descriptions of the medicines inside them. The pharmacy routinely supplied patient information leaflets alongside compliance packs at the beginning of each four-week cycle.

The pharmacy sourced medicines from licensed wholesalers. It generally stored medicines in an orderly manner on shelves within the dispensary. But storage shelves were shallow and as a result the team stored some overflow stock at floor level against the edges of shelving units. This was not ideal, but efforts were made to ensure the stock didn't cause any risk of a trip or fall. Random checks of dispensary stock found several medicines removed from their original blister packaging and stored in amber bottles or loose within their original box. The team took appropriate action to dispose of these medicines. And a discussion highlighted the need to identify and manage risks associated with storing medicines once removed from their original packaging. The pharmacy stored medicines requiring safe custody in secure cabinets. Medicines inside the cabinets were stored in an orderly manner with separate areas for holding assembled medicines, out-of-date medicines, and patient-returned medicines. The pharmacy had three fridges used to store medicines requiring cold storage. Medicines inside were held in an orderly manner and fridge temperature records confirmed they were operating within the correct temperature range of two and eight degrees Celsius.

Pharmacy team members acknowledged they had fallen behind with some stock management tasks associated with date checking stock medicines. They took care during the dispensing process to check expiry dates to reduce the risk of supplying an out-of-date medicine. And the team used the inspection as an opportunity to explore options to support it in getting back on track with routine scheduled date checking tasks designed to further mitigate risk. The team annotated liquid medicines with details of their shortened shelf-life once opened. The pharmacy had appropriate medicinal waste bins and CD denaturing kits available. It received and actioned medicine alerts electronically through a task tracker system on its intranet. It kept an audit trail of the actions it completed in response to these alerts.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs to support the safe delivery of its services. It maintains its equipment to ensure it remains fit for purpose and safe to use. And its team members use the equipment in a way which protects people's privacy.

Inspector's evidence

Pharmacy team members had access to both hard copy and digital reference resources. They used the intranet and internet to support them in obtaining information when providing advice to people. The layout of the premises protected information on the pharmacy's computer monitors from unauthorised view. And team members used NHS smart cards and passwords when accessing people's medication record. The pharmacy stored bags of assembled medicines on shelving to the side of the dispensary. This arrangement effectively protected people's personal information.

The pharmacy had a range of clean and suitable equipment to support its team members in counting and measuring medicines. For example, crown stamped glass measures to accurately measure liquid medicines. Specific measures were highlighted for use with higher-risk medicines to mitigate the risk of cross contamination. Equipment used to support the delivery of pharmacy services was from reputable manufacturers. For example, the pharmacy's blood pressure monitors were on the list of monitors validated for use by the British and Irish Hypertension Society. There was a procedure to support appropriate cleaning of this equipment between use. The pharmacy's electrical equipment had last been subject to portable appliance testing in 2022.

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.