General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Well, 209 Park Lane, MACCLESFIELD, Cheshire, SK11 6UD

Pharmacy reference: 1029651

Type of pharmacy: Community

Date of inspection: 19/09/2019

Pharmacy context

This is a community pharmacy in a residential area of Macclesfield. The pharmacy sells over-the-counter medicines and dispenses NHS prescriptions. It also dispenses private prescriptions. The pharmacy team offers advice to people about minor illnesses and long-term conditions. And it offers services including medicines use reviews (MURs), a substance misuse service and the NHS New Medicines Service (NMS). It also supplies medicines in multi-compartmental compliance packs to people living in their own homes and some local care 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	1.2	Good practice	The pharmacy is good at recording and learning from any errors the team make when dispensing. The team members take steps to improve their dispensing accuracy and make sure they do not make the same errors again.
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 has suitable processes and written procedures to protect the safety and wellbeing of people who access its services. It is good at recording and learning from any errors the team make when dispensing. And the team members take steps to improve their dispensing accuracy to make sure they don't make the same error again. The pharmacy team members have the knowledge necessary to protect the welfare of children and vulnerable adults. And they have some processes and training in place to support them. The pharmacy mostly keeps the records it must by law and it keeps people's private information safe.

Inspector's evidence

The pharmacy had a large open plan retail area which led up to the pharmacy counter and on into the dispensary. It had a private consultation room to the side of the retail area. The responsible pharmacist used the bench closest to the pharmacy counter to do final checks on prescriptions. This helped her supervise and oversee sales of over-the-counter medicines and conversations between team members and people at the counter.

The pharmacy had a set of standard operating procedures (SOPs). And these were held electronically. The superintendent pharmacist's team reviewed each SOP every two years on a monthly rolling cycle. This ensured that they were up to date. The pharmacy defined the roles of the pharmacy team members in each SOP. The SOP showed who was responsible for performing each task. The team members said they would ask the pharmacist if there was a task they were unsure about. Or felt unable to deal with. The superintendent pharmacist's team sent new and updated SOPs to the team via the eExpert training programme. The team members completed a short quiz once they had read the SOP. They needed to pass the quiz to be signed off as having read and understood its contents.

The pharmacy had a process to record near miss errors that were spotted during dispensing. The final checker typically spotted the error and then informed the dispenser that they had made an error. The dispenser made a record of the error onto an electronic reporting system called Datix. The records contained details such as the date of the error and the team members involved. The team members had recently discussed the importance of entering their errors straight away to make sure they did not forget to do so. And, they took responsibility for their own errors. They discussed any errors with each other while they were making the entries on Datix. This was to allow them to learn from each other. A trainee pharmacy assistant completed entries with the help of the regular pharmacist. She stated that this helped her have a more in-depth discussion about why the error happened and how she could prevent it happening again. The near miss errors were analysed each month for any trends and patterns. And the findings were documented for future reference and discussed with the team in a monthly team meeting. The team members made several changes to prevent errors happening again. These included attaching alert stickers in front of medicines that had been commonly involved in picking errors such as 'look-a-like, sound-a-like' medicines, known as LASAs. A list of the most common LASAs was displayed on a poster on the dispensary wall. The pharmacy had a process to record dispensing errors that had been given out to people. And it recorded these incidents on Datix. A copy of the report was sent to the superintendent pharmacist's office for analysis and kept in the pharmacy for future reference. The pharmacy had recently supplied a medicine in error. The error was due to two medicines having similar names. The team members discussed ways they could stop a similar error

happening in the future. They highlighted the importance of reading through prescriptions thoroughly and making sure they dispensed from the prescription and not the computer-generated labels.

The pharmacy had a poster on display which advertised how people could make comments, suggestions and complaints. It detailed the company head office address, email and telephone number. But it was located behind a retail display and so people could not see it. The pharmacy collected feedback from people through an annual survey and mystery shopper visits. The pharmacy had achieved a 98% score following the latest mystery shopper visit. The visit assessed many aspects of the pharmacy including the cleanliness of the premises, the layout of the retail area, the time taken to be served and the clinical knowledge of the team members when they were asked about an over-the-counter medicine.

The pharmacy had up-to-date professional indemnity insurance. The responsible pharmacist notice displayed the correct details of the responsible pharmacist on duty. Entries in the responsible pharmacist record complied with legal requirements. The pharmacy kept complete records of private prescriptions and emergency supplies. The pharmacy kept the certificates of conformity of special supplies. But in a sample seen, they were not always completed correctly as required by the Medicines and Healthcare products Regulatory Agency (MHRA). The pharmacy kept controlled drugs (CDs) registers. They were in order including completed headers, and entries made in chronological order. The pharmacy team checked the running balances against physical stock each week. The running balance of Concerta 54mg XL tablets was checked and it matched the physical stock. The pharmacy kept complete records of CDs returned by people to the pharmacy.

The team held records containing personal identifiable information in areas of the pharmacy that only team members could access. Confidential waste was placed into a separate bin to avoid a mix up with general waste. The confidential waste was destroyed periodically. The pharmacy displayed a poster explaining how people's information was used and stored. The team members understood the importance of keeping people’s information secure. And they had all completed training on information governance. They renewed their training each year via an online training module. Some team members had completed training on safeguarding vulnerable adults and children via the eExpert online training programme. And the regular pharmacist and the pharmacy’s manager had completed additional training via the Centre for Pharmacy Postgraduate Education. The team members gave several examples of symptoms that would raise their concerns. And how they would discuss their concerns with the pharmacist on duty, at the earliest opportunity. The team members had some guidance readily available to them to help properly manage and report a potential concern. And they knew to contact the local safeguarding teams or the superintendent pharmacist’s office for advice if they had any concerns.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough suitably skilled team members to manage the services it provides. The pharmacy appropriately reviews and updates its staffing levels, after an increase in workload. This includes the recruitment of additional team members to make sure the staffing levels and skill mix remain appropriate. The team members openly discuss ways to improve ways of working. And they regularly talk together about why mistakes happen, and how they can make improvements. The pharmacy supports its team members to ensure their knowledge and skills are up to date. It achieves this by providing its team members with a regular training programme and appraisals of performance. And they feel comfortable to raise professional concerns when necessary.

Inspector's evidence

At the time of the inspection, the team members present were the regular pharmacist, a full-time accuracy checking technician (ACT) who was also the pharmacy's manager, two full-time pharmacy assistants and a part-time trainee pharmacy assistant. Two pharmacy assistants and two pharmacy technicians were not present during the inspection. The team members did not take time off in the few weeks before Christmas. As this was the pharmacy's busiest period. The pharmacy could call on the help of team members from other local Well branches to cover planned and unplanned absences. The regular pharmacist did not work on alternate Tuesdays or Saturdays. The pharmacy used locum pharmacists to cover her absence. The pharmacy manager said that she had recently asked for only pharmacists who were trained in providing flu vaccinations to be employed to make sure the service was not disrupted in the absence of the regular pharmacist. In the previous 3 months the pharmacy had started dispensing medicines in multi-compartmental compliance packs to an additional 100 people. These people had previously had their medicines dispensed from a neighbouring Well pharmacy. The pharmacy had also started dispensing medicines for 2 new local care homes. It was also due to change its electronic patient medication record software. The pharmacy had recently employed 2 new full-time team members to assist with the increased workload. The pharmacist was seen supervising the team members while they worked. And they involved the pharmacist in offering advice to people who were purchasing over-the-counter products for various minor ailments. They carried out tasks and managed their workload in a competent manner. The team members accurately described the tasks that they could and could not perform in the pharmacist's absence.

The team members were able to access the online training system to help them keep their knowledge and skills up to date. They received training modules to complete every month. Many of the modules were mandatory to complete. The team members were also able to voluntarily choose a module if they felt the need to learn about a specific healthcare related topic, or needed help carrying out a certain process. The team members did not receive set time during the working day to allow them to complete the modules. A team member said she preferred to complete the modules in her own time, without any distractions. The team member showed she had completed 93 percent of the mandatory modules. The pharmacy had an annual performance appraisal process in place. Before each appraisal, they team members assessed their own performance over the last year. They discussed their assessment with the pharmacy's manager in a one-to-one meeting. They also discussed what parts of their roles they felt they enjoyed and which parts they felt they wanted to improve. They could give feedback on how to improve the pharmacy's services. And discuss their personal development. The pharmacy manager said the team members had recently discussed setting up a flu vaccination clinic for employees of local care

homes.

The team held monthly formal meetings and discussed topics such as company news, targets and patient safety. If a team member was not present during the discussions, they were updated the next time they attended for work. The team members openly and honestly discussed any mistakes they had made while dispensing and discussed how they could prevent the mistakes from happening again. The team members said they were able to discuss any professional concerns with the manager or with the company head office. The pharmacy had a whistleblowing policy. So, the team could raise a concern anonymously. The pharmacy set several targets for its team to achieve. These included services and prescription volume. The team members were well supported to help them achieve the targets. And they were not put under any pressure to achieve them.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is secure, clean and properly maintained. It provides a suitable space for the health services provided. And, it has a suitable room where people can speak to pharmacy team members privately.

Inspector's evidence

The pharmacy was clean and appeared professional. The building was easily identifiable as a pharmacy from the outside. The dispensary was cluttered during the inspection with many baskets awaiting a final check, and the team members did not have much space to dispense the medicines for the care homes. However, this improved as the inspection progressed. The pharmacy was undergoing building work on the first floor of the premises. This was to create a new room for the team members to use to dispense medicines in multi-compartmental compliance packs. The team members said they were looking forward to its completion as it would help them to better organise the workflow.

There was a clean, well-maintained sink in the dispensary for medicines preparation and staff use. There was a WC which had a sink with hot and cold running water and other facilities for hand washing. The pharmacy had a sound-proofed consultation room which contained adequate seating facilities. The room was smart and professional in appearance and was signposted by a sign on the door. The room was kept locked when not in use. The temperature was comfortable throughout the inspection. Lighting was bright throughout the premises.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's services are easily accessible to people. The team members take reasonable steps to identify people taking high-risk medicines. And, they provide these people with appropriate advice to help them take these medicines safely. The pharmacy sources its medicines from licenced suppliers. And it stores and manages its medicines appropriately. The pharmacy dispenses medicines in multi-compartmental compliance packs to help people take their medicines correctly. And the team members manage the service appropriately and effectively.

Inspector's evidence

The pharmacy had level access from the street to an automatic door. Large print labels were provided on request. The team members had access to the internet. Which they used to signpost people requiring a service that the team did not offer. The pharmacy advertised its services and opening hours in the front window. Seating was provided for people waiting for prescriptions.

The team members regularly used various stickers that they could use as an alert before they handed out medicines to people. For example, to highlight interactions between medicines or the presence of a fridge line or a controlled drug that needed handing out at the same time. The team members signed the dispensing labels to indicate who had dispensed and checked the medication. And so, a robust audit trail was in place. The dispensary had a manageable workflow with separate areas for the team members to undertake the dispensing and checking parts of the dispensing process. Baskets were available to hold prescriptions and medicines. This helped the team stop people's prescriptions from getting mixed up. The team had a robust process to highlight the expiry date of CD prescriptions awaiting collection in the retrieval area. Owing slips were given to people on occasions when the pharmacy could not supply the full quantity prescribed. One slip was given to the person. And one kept with the original prescription for reference when dispensing and checking the remaining quantity. The team attempted to complete the owing the next day. The pharmacy kept records of the delivery of medicines from the pharmacy to people. The records included a signature of receipt. So, there was an audit trail that could be used to solve any queries. A note was posted to people when a delivery could not be completed. The note advised them to contact the pharmacy.

The pharmacy often dispensed high-risk medicines for people such as warfarin. The pharmacist often gave the person additional advice if there was a need to do so. The team occasionally recorded details of the conversations if they were significant, for example a discussion about a change in dose or directions. The team was aware of the pregnancy prevention programme for people who were prescribed valproate and of the risks. And they demonstrated the advice they would give people in a hypothetical situation. The team had access to literature about the programme to provide to people to help them take their medicines safely. The team had completed a check to see if any of its regular patients were prescribed valproate. And met the requirements of the programme. One person had been identified. And the pharmacist had completed an MUR with the person. The pharmacy used clear bags to store dispensed insulin. This allowed the team member and the person collection to undertake a final visual check of the medicine before the person collected the medicine.

The pharmacy supplied medicines in multi-compartmental compliance packs for people living in their own homes and living in five local care homes. And the pharmacy supplied the packs to people on

either a weekly or monthly basis. The team members were responsible for ordering prescriptions of people living in their own homes. And they did this around a week in advance. And then they cross-referenced the prescription with a master sheet to ensure it was accurate. The team members queried any discrepancies with the person's prescriber. The team members recorded details of any changes, such as dosage increases and decreases, on the master sheets. The packs had backing sheets which listed the medicines in the packs and the directions. The pharmacy supplied information to help people visually identify the medicines. For example, the colour or shape of the tablet or capsule. It also routinely provided patient information leaflets with the packs.

Pharmacy only medicines were stored behind the pharmacy counter. The storage arrangement prevented people from self-selecting these medicines. Every three months, the pharmacy team members checked the expiry dates of its medicines to make sure none had expired. And records were seen. The pharmacy used stickers to highlight stock that was within six months of expiring. Some short-dated stickers were seen on items on the dispensary shelves. No out-of-date medicines were found following a random check. The team members recorded the date liquid medicines were opened on the pack. So, they could check they were in date and safe to supply. The pharmacy had a robust procedure in place to appropriately store and then destroy medicines that had been returned by people.

The team were not currently scanning products or undertaking manual checks of tamper evident seals on packs, as required under the Falsified Medicines Directive (FMD). The team had received training on how to follow the directive. The pharmacy had FMD software and scanners installed. The team was unsure of when they were to start following the directive. Drug alerts were received via email to the pharmacy and actioned. The alerts were printed and stored in a folder. And the team kept a record of the action it had taken. The pharmacy had two fridges. And the team members checked the temperatures of each fridge each day. To make sure they were within the correct ranges. A sample of the records was seen. And was within the correct limits.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy's equipment is clean and safe, and the pharmacy uses it appropriately to protect people's confidentiality.

Inspector's evidence

The pharmacy had copies of the BNF and the BNF for children for the team to use. And the team had access to the internet as an additional resource. The pharmacy used a range of CE quality marked measuring cylinders. The team used tweezers and rollers to help dispense multi-compartmental compliance packs. The fridges used to store medicines were of an appropriate size. And the medicines inside were organised in an orderly manner. All the electrical equipment looked in good condition and was working. Prescription medication waiting to be collected was stored in a way that prevented people's confidential information being seen by members of the public. And computer screens were positioned to ensure confidential information wasn't seen by people. The computers were password protected to prevent any unauthorised access. The pharmacy had cordless phones, so the team members could have conversations with people in private

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.