General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Well, 11 Fountain Square, Disley, NEAR STOCKPORT, Cheshire, SK12 2AB

Pharmacy reference: 1029740

Type of pharmacy: Community

Date of inspection: 04/10/2019

Pharmacy context

This is a community pharmacy in a parade of shops in the centre of Disley, Cheshire. 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) and the NHS New Medicines Service (NMS). It administers flu vaccinations and supplies medicines to people in multi-compartmental compliance packs. The pharmacy delivers medicines 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 has suitable processes and written procedures to protect the safety and wellbeing of people who use its services. It keeps the records it must have by law and keeps people's private information safe. It advertises how people can raise concerns. And it asks for people for their views on the pharmacy's services. The pharmacy team members have the knowledge to protect the welfare of children and vulnerable adults. And they have some processes and training in place to support them. Although the team members do not record every error they make whilst dispensing, they informally discuss them to learn from each other's mistakes. And they take steps to reduce the risk of making a similar error in the future.

Inspector's evidence

The pharmacy was busy at the time of the inspection and had a constant flow of people coming in to purchase over-the-counter medicines, collect medicines dispensed from prescriptions and wishing to have a flu vaccination. There was a separate bench from where the pharmacist on duty completed final checks on prescriptions. The bench was close to the retail counter. This helped the pharmacist 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 pharmacist on duty typically spotted the error and then informed the dispenser that they had made an error. The dispensers then recorded the details of the error onto a paper near miss log. The records were then transferred onto an electronic reporting system called Datix. The team members did not record every near miss as they did not always have the time to do so. No records were seen from August 2019. But they tried to discuss any near misses with each other as soon as they were noticed to help them learn from each other's mistakes. The details of the entries in the paper near miss log were vague and the team members did not always record the reason why the error had happened. And so, they may have missed out on the opportunity to make specific changes to the way they work to ensure the error was not repeated. The team was required to complete a formal analysis of the near miss errors each month. The purpose of the analysis was for the team to identify any patterns or trends and to then consider ways to improve their accuracy. But the team had not completed an analysis for a few months. The team members believed the most common reason for errors was due to them rushing or not taking enough care when they were selecting medicines. They had discussed slowing down their dispensing process to ensure they were being more careful when dispensing. They had not investigated the potential causes of mistakes any further. The team members demonstrated some general changes they had made to prevent errors repeating. For example, they had attached warning stickers next to

where the pharmacy stored propranolol 10mg and 40mg, as their packaging was very similar in appearance. The warning stickers advised the team members to take extra care when selecting these medicines. The pharmacy had a clear process to manage and report dispensing errors that had been given out to people. It recorded these incidents on the Datix system and printed out a copy which was kept in the pharmacy for future reference. The details of these incidents were also reported to the pharmacy's superintendent office. The pharmacy had recently incorrectly supplied a person with the lower strength of a controlled drug (CD). The team discussed what could be done to prevent a similar error happening again. The team decided to have a triple check of all CD medicines instead of a double check. The pharmacy had not had any similar errors since the measure was implemented.

The pharmacy advertised how people could make comments, suggestions and complaints, though a poster displayed in the retail area. The pharmacy collected feedback from people through an annual survey and mystery shopper visits. And it had a procedure for handling complaints and concerns raised by people using the pharmacy. The pharmacy completed an annual customer satisfaction survey. But no records were available for inspection. And the team members could not give any examples of changes made to improve services following any feedback they had received from people.

The pharmacy had up-to-date professional indemnity insurance. The responsible pharmacist notice displayed the correct details of the responsible pharmacist on duty. But it was hard to see from the retail area. This is not in line with requirements. Entries in the responsible pharmacist record complied with legal requirements. The pharmacy kept complete records of private prescription and emergency supplies. The pharmacy kept the certificates of conformity of special supplies. And they were 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 a random CD 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. A specialist third party contractor periodically destroyed the confidential waste. 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. A poster was on display in the retail area which explained how the pharmacy managed people's personal information. The team members had recently made some changes to the way they worked following an information governance incident. They explained that a person had received another person's repeat prescription slip by mistake. The pharmacy carried out an investigation and realised that a team member had put the repeat slip into a medication bag by mistake. The team members discussed how they could prevent a similar mistake from happening again. And they made changes to the way they handled repeat slips.

The team members were asked about how they were equipped to safeguard the welfare of vulnerable adults and children. Each member described several examples of symptoms that would cause them concern and how they would refer every potential concern to the pharmacist on duty. Each team member present during the inspection had completed training on safeguarding via the eExpert training system. And the pharmacist on duty had completed training via the Centre for Pharmacy Postgraduate Education. The team members didn't have any written guidance to help them manage a concern. But they could call the pharmacy's superintendent pharmacist's office for advice.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough qualified and skilled team members to manage the services it provides. The team members openly discuss how 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 training programme and regular appraisals. They can make suggestions to improve the pharmacy's services. And they feel comfortable to raise professional concerns when necessary.

Inspector's evidence

At the time of the inspection, the team members present were a relief pharmacist and three pharmacy assistants. Another pharmacy assistant who was also the pharmacy manager was not present during the inspection. The pharmacy had not had a regular pharmacist for around seven months and had been using a pool of locum pharmacists. The team members had found this time challenging particularly when locums were unable to provide services such as flu vaccinations. The pharmacy had recently employed the pharmacy manager and the team members said that they had started completing processes that had previously been overlooked such as having team meetings. 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 staff rotas had been recently reviewed after staff hours had been reduced. And some team members had changed their working hours to fill in some gaps to ensure staffing levels were at an appropriate level. The pharmacist was seen supervising the team members. 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 they completed some training when the pharmacy was quiet but often preferred to complete the modules in their own time, without any distractions. The team member showed they had completed almost all the mandatory modules. The pharmacy had an annual performance appraisal process in place. The appraisals were an opportunity for the team members to discuss what parts of their roles they felt they enjoyed and which parts they felt they wanted to improve. And discuss their personal development.

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 meetings were also an opportunity for the team to give feedback and ideas on how they could improve the pharmacy's services. But the team was unable to provide any examples.

The team members said they were able to discuss any professional concerns with the pharmacist, area 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 the number of flu vaccinations administered and the number of prescription items dispensed. The team was not under any significant pressure to achieve the targets and they felt supported by each other to provide services to a high standard.

Principle 3 - Premises ✔ Standards met

Summary findings

The areas of the premises that can be accessed by the public are clean and properly maintained. But the staff areas could be tidier and better maintained. The pharmacy is properly secured from unauthorised access. There is a suitable room where people can speak to pharmacy team members privately.

Inspector's evidence

The pharmacy's exterior was professional in appearance, well maintained and easily identifiable as a pharmacy. The pharmacy had a small retail area which was clean, tidy and well organised. The dispensary was located behind the retail area and was small for the dispensing workload and bench space was limited. The benches were cluttered with various baskets and paperwork, but this improved as the inspection progressed. There were many boxes containing stock on the floor of the dispensary. But they were stored tidily to reduce the risk of a trip or fall. Stairs led to the first floor. The stairs were cluttered with several items such as bags. On the first floor there was a stock room which was disorganised with many items placed on the floor. And so, there were several trip hazards. The pharmacy had a private consultation room available. The pharmacy team used the room to have private conversations with people. The room was soundproofed and signposted by a sign on the door.

There was a clean, well maintained sink in the dispensary used for medicines preparation. There was a toilet, which provided a sink with hot and cold running water and other facilities for hand washing. But the toilet had a significant amount of mould on the walls. The issue had been raised with the company's head office several months ago, but it had not been resolved. 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 generally 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 is good at identifying people who would benefit from a seasonal flu vaccination. And the service is popular. The pharmacy supplies medicines to some people in multi-compartment compliance packs to help them take them correctly. And it appropriately manages the risks associated with the services. The pharmacy sources its medicines from licenced suppliers. And it stores and manages its medicines appropriately.

Inspector's evidence

The pharmacy could be accessed from a step from the street which led to a push/pull door. There was a sign in the main window instructing people to 'press bell for assistance'. But a bell was not installed. The team members explained that people with mobility issues often knocked on the door to get their attention and they helped them with their queries at entrance door. The pharmacy did not have a portable ramp to allow people with wheelchairs or pushchairs to enter the premises. A hearing loop was installed to help people with a hearing impairment. And the pharmacy could provide people with a visual impairment with large print dispensing labels. It advertised its opening hours and the services offered in the main window. The team members had access to the internet to help them signpost people if they asked for a service that the pharmacy did not offer.

The pharmacy offered a popular flu vaccination service. During the inspection, the team members were seen offering the service to every person who was eligible. The pharmacist adminstered flu vaccinations to several people during the inspection. The pharmacy had provided over 200 flu vaccinations since September 2019. But the service was not offered every day the pharmacy was open. This was because the team members were not always aware if a locum pharmacist who was due to work at the pharmacy, was trained to provide the service. The team members said they tried to work around this problem by telling people to visit the pharmacy on specific days when they knew a locum qualified to provide the service, was due to work. They often rang other branches where a locum was working to ask them if they had completed the training and requested that the company's head office book the locum at the pharmacy. But this did not always happen. The pharmacy had identified and managed several risks associated with the service. This included ensuring that the consultation room was clean and tidy, and there was nothing obstructing the opening of the consultation room door to allow them to help any person easily enter and leave the room. There were two adrenaline pens stored in the room. These could be used to help a person in the rare event of them suffering an anaphylactic reaction to the vaccination.

The team members had various stickers that they regularly used 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 in the appropriate area of the dispensing labels to indicate who had dispensed and checked the medication. And so, a robust audit trail was in place. 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. But the records rarely included a signature of receipt. And so, there wasn't a complete audit trail in place that could be used to solve any queries. This was not in line with the pharmacy's SOPs. A note was posted to people when a delivery could not be completed. The note advised them to contact the pharmacy.

The pharmacy supplied medicines in multi-compartmental compliance packs for around 60 people living in their own homes. And the pharmacy supplied the packs to people on either a weekly or monthly basis. The team members were responsible for ordering the prescriptions. 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 packs had backing sheets attached 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. The team members recorded the details of any changes such as dosage increases or decreases in a medication event diary. They kept the details of when the change was authorised and who had authorised it. They made a record of any people on the service who had been admitted to hospital. And they stopped dispensing into the packs until they were told the person had returned home. The team members said it was important that they were aware of any changes to a person's medicines after they had been discharged from hospital. They worked with the person's GP surgery to make sure they accurately dispensed their medication when the next packs were due.

The pharmacy 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. And the team recorded details of the conversations if they were significant, for example a discussion about a change in dose or directions. They were aware of the pregnancy prevention programme for people who were prescribed valproate and of the risks. They demonstrated the advice they would give people in a hypothetical situation. The team had access to literature about the programme that they could 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 person was provided with advice about the programme. The pharmacy used clear bags to store dispensed insulin and controlled drugs. This allowed the team member and the person collection to undertake a final visual check of the medicine before the person collected the medicine.

Pharmacy only medicines were stored behind the pharmacy counter. The storage arrangement prevented people from self-selecting these medicines. The pharmacy stored its medicines in the dispensary tidily and they were easy to find. 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 was 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. But the team was unsure of when the changes to follow the directive would start. 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 checked and recorded the fridge temperature ranges each day. A sample was looked at. And it was within the

correct ranges.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy's equipment is clean and suitable for the services it provides. The pharmacy uses its equipment 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. 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.