General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Well, 60-62 Alderley Road, WILMSLOW, Cheshire, SK9 1PA

Pharmacy reference: 1029875

Type of pharmacy: Community

Date of inspection: 28/02/2020

Pharmacy context

This is a community pharmacy inside a health centre in the village of Wilmslow, Cheshire. It dispenses both NHS and private prescriptions and sells a range of over-the-counter medicines. The pharmacy team offers advice to people about minor illnesses and long-term conditions through its NHS services. And it provides a home delivery service.

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 has an up-to-date set of procedures to identify and manage risks to its services. The pharmacy's team members follow them to make sure they work safely and effectively. The pharmacy keeps the records it must have by law. And it keeps people's private information secure. The team members know when and how to raise a concern to safeguard the welfare of vulnerable adults and children. They record some of the mistakes that happen within the dispensing process. But they don't record the details of each mistake. So, they may have missed out on the opportunity to learn from their mistakes. And make changes to improve their ways of working.

Inspector's evidence

The pharmacy had a set of up-to-date electronic standard operating instructions (SOPs) in place. The superintendent pharmacist's office reviewed the procedure every two years on a monthly rolling cycle. It sent new and updated procedures to pharmacy team members via the eExpert online training system approximately each month. Once the team members had read the contents of the SOP, they needed to complete a short quiz to test their understanding. They had to pass the quiz to be signed of as having read and understood the SOP. The pharmacy defined the roles of the pharmacy team members in each procedure. Which made clear the roles and responsibilities within the team.

The pharmacy had a procedure to record any near miss errors made while dispensing. The pharmacist who identified the near miss error and the dispenser had a brief discussion about the error immediately after it was identified. The dispenser was required to record the details of the near miss on an electronic reporting system called Datix. They recorded the date, time and a brief description of the near miss error. But the team members explained they did not always have the time to record each near miss error due to the volume of prescriptions they were dispensing. The team completed some basic analysis of the near misses to look for any trends or patterns. They had recently talked about taking extra care when dispensing medicines that looked or sounded alike, known as LASA medicines. The pharmacy had a process for dealing with dispensing errors that had been given out to people. It recorded incidents on the Datix system. And kept a paper copy in the pharmacy for future reference and learning. The records included details of the action taken to reduce the risk of a similar error happening again. For example, the need to take more care when dispensing medicines that were available in different strengths.

The pharmacy was displaying the correct responsible pharmacist notice at the time of the inspection. The team members explained their roles and responsibilities. And they were seen working within the scope of their role throughout the inspection. The team members accurately described the tasks they could and couldn't do in the absence of a responsible pharmacist. For example, they explained how they could only hand out dispensed medicines or sell any pharmacy medicines under the supervision of a responsible pharmacist.

The pharmacy had a formal complaints procedure. And it was on display in the retail area for people to see. People who used the pharmacy could discuss any concerns or complaints they had with any of the team members. And if the problem could not be resolved, it would be escalated to the pharmacy's superintendent pharmacist's team. The pharmacy collected feedback each year through questionnaires that were placed on the pharmacy counter for people to self-select and complete.

The pharmacy had up-to-date professional indemnity insurance. Entries in the responsible pharmacist record complied with legal requirements. The pharmacy kept complete records of private prescriptions and emergency supplies. The pharmacy kept controlled drugs (CDs) registers. And they were completed correctly. A physical balance check of a randomly selected CD matched the balance in the register. The team completed a full balance check of the CDs every month. The pharmacy kept complete records of CDs returned by people to the pharmacy. The pharmacy held certificates of conformity for unlicensed medicines and they were completed in line with the requirements of the Medicines & Healthcare products Regulatory Agency (MHRA).

The pharmacy outlined how it handled personal and sensitive data through a privacy notice in the retail area. The team members had undertaken training on General Data Protection Regulation (GDPR). They were aware of the need to keep people's personal information confidential. 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 periodically collected by a third-party contractor and securely destroyed.

The responsible pharmacist had completed training on safeguarding vulnerable adults and children through the Centre for Pharmacy Postgraduate Education (CPPE). When asked about safeguarding, the team members gave several examples of the symptoms that would raise their concerns in both children and vulnerable adults. A team member explained how she would discuss her concerns with the pharmacist on duty. If the team members needed further guidance, they explained they would contact the pharmacy’s superintendent pharmacist’s office for support.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy team members have the appropriate qualifications and skills to provide the pharmacy's services safely and effectively. Although they sometimes work under pressure, they work well to support each other to manage the dispensing workload. The pharmacy team members complete training relevant to their role, to keep their knowledge and skills up to date. They can make suggestions to improve the pharmacy's services. And they have facilities to raise professional concerns if necessary.

Inspector's evidence

The responsible pharmacist at the time of the inspection was a locum pharmacist and was working at the pharmacy for the first time. The pharmacy had been without a regular pharmacist for about a month. The team members explained that the time had been challenging and they were often under pressure to complete the dispensing workload in a timely manner. The pharmacy had reviewed a recent decision to reduce the pharmacy dispensing hours to help support the team. During the first half of the inspection the pharmacist was supported by two part-time dispensers. The team was observed working under some pressure to get people's medicines dispensed. But they were managing the workload. Another pharmacy assistant joined the team for the second half of the inspection, which helped relieve some of the pressures of the dispensing workload. And the team were seen to be working more efficiently and effectively.

The pharmacy provided the team members with a structured training programme. The programme involved team members completing various e-learning modules through the eExpert online system. The modules covered various topics including health and safety, new and revised SOPs and health conditions such as pain relief. Some modules were mandatory and others could be chosen voluntarily in response to an identified training need. The team members received protected training time during the working day to complete the modules. So, they could do so without any distractions. But they were not always able to take the time because of the dispensing workload. The team members received a performance appraisal every six months. The team members were asked to assess their own performance and were given the opportunity to discuss any personal goals they wanted to achieve and give feedback on ways to improve the pharmacy's services. They had recently made posters to place around the retail area to outline when people's medicines would be ready after they had ordered their prescriptions at the adjacent health centre.

The team members could raise professional concerns with the pharmacy's regional development manager. The pharmacy had a whistleblowing policy. So, the team members could raise concerns anonymously. The pharmacy set the team various targets to achieve. These included the number of prescription items dispensed and the number of services provided. The targets did not impact on the ability of the team to make professional judgements.

Principle 3 - Premises ✔ Standards met

Summary findings

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

Inspector's evidence

The pharmacy was clean and professional in its appearance. There was a sign in the car park of the health centre which indicated there was a pharmacy inside the building. The retail area was small, and at several times during the inspection it was full of people who were waiting for their medicines to be dispensed. This meant the team members had to confirm names and address with people who were collecting their medicines, and discuss their health, in proximity of other people. They managed this risk by speaking quietly with people or by moving to a quieter part of the retail area. The pharmacy had a consultation room with seats where people could sit down with a team member to have a private consultation. It was not used during the inspection. The room was signposted by a sign on the door. The pharmacy had some chairs placed close to the room in the retail area. The chairs were used by people who were waiting for their medicines to be dispensed. It was possible to hear conversations people were having in the retail area from inside the consultation room. So, the room may not be well soundproofed. The floor of the room was also used to store several items including amber bottles and some meal replacement drinks. This did not portray a professional environment. The team explained they had to use the room due to a lack of space in the dispensary.

The dispensary was generally kept tidy and well organised during the inspection, and the team used the bench space well to organise the workflow. The floor spaces were cluttered during the inspection with boxes of medicines that had been delivered to the pharmacy. So, there was a risk of a trip or a fall. But this improved as the inspection progressed. There was a clean, well-maintained sink in the dispensary for medicines preparation and staff use. The team had access to a toilet with a sink with hot and cold running water and other facilities for hand washing. 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 pharmacy manages its services appropriately and delivers them safely. And it uses an offsite pharmacy dispensing hub to help manage the dispensing workload more effectively. The pharmacy obtains its medicines from reputable sources. And it stores and manages its medicines safely and securely.

Inspector's evidence

The pharmacy was accessible via steps from the health centre car park. There was level access to the health centre and a lift could be used to access the pharmacy. So, people with prams or wheelchairs could easily access the premises. The pharmacy could provide people with large print dispensing labels if they had a visual impairment. The pharmacy advertised its services and opening hours in main window. And there were several healthcare related leaflets available for people to select and take away with them. There was a healthy living zone in the retail area. The zone displayed information on various healthcare related topics.

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 if a medicine caused drowsiness, 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. Baskets were available to hold prescriptions and medicines to help manage the workflow efficiently. The team had a robust process to highlight the expiry date of CD prescriptions awaiting collection in the retrieval area. The team members gave people owing slips when they could not supply the full prescribed quantity. One slip was given to the person. And one kept with the original prescription for reference when the remaining quantity was dispensed and checked. 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 had introduced a new system for dispensing many of the prescriptions it received, at the company's offsite dispensing hub. The system was designed to reduce the team's dispensing workload and allow the team members more time to offer services. The team members explained the system had helped them manage the workload better. But they often found some people who used the pharmacy felt the time taken for their medicines to arrive at the pharmacy from the hub, was too long. The team members explained they informed people who were new to the pharmacy, that their medicines may be dispensed at the hub. And more recently they were being clear to people about when their medicines would arrive at the pharmacy. Each dispenser had received comprehensive training before the process went live. The team firstly assessed whether a prescription was suitable to be dispensed at the hub. Any prescriptions that were for CDs or fridge items were not sent. The team also avoided sending prescriptions for more urgent items such as antibiotics. Once it was established that a prescription was suitable to be sent to the hub, the data was entered. And then the pharmacist completed an accuracy and clinical check. Only the pharmacist, using their personal smart card and password, was able to perform the clinical and accuracy check and release prescriptions to the hub. The details of the prescription were then sent electronically to the hub. And the prescription was assembled using automation. The team marked all prescriptions that were sent to the hub and stored them in a separate

box to prevent them being mixed up with other prescriptions. The pharmacy received the medicines that had been dispensed at the hub in sealed bags. The bags were then coupled with the relevant prescription. And then scanned on the shelves in the prescription retrieval area, ready for collection. Each day the pharmacist opened two randomly selected bag that had been dispensed at the hub and completed another accuracy check. This was to ensure the pharmacy completed a regular quality check.

The pharmacy dispensed high-risk medicines for people. The team members used alert stickers attached to people's medication bags to remind the person handing out that the bag contained a high-risk medicine. They explained they made sure to inform the pharmacist on duty if the bag contained warfarin. So, the pharmacist could appropriately counsel the person. For example, asking if they had a recent blood test. They used 'antibiotic' stickers. These stickers reminded the team to ask people collecting antibiotics if they had any allergies and to remember to complete the full course. The team members were aware of the pregnancy prevention programme for people who were prescribed valproate and of the risks. The team had completed a check to see if any of its regular patients were prescribed valproate. And met the requirements of the programme. Those identified were enrolled on the programme and were given advice about the risks of becoming pregnant while taking valproate. The pharmacy dispensed fridge and CD items in clear bags. Which allowed the team members to complete a final visual check of the medicine before they handed them out to people.

Pharmacy medicines (P) were stored behind the pharmacy counter. So, the pharmacist could supervise sales appropriately. The medicines in the dispensary were tidily stored. Every three months, the team members checked the expiry dates of its medicines to make sure none had expired. The team demonstrated up-to-date records of the process. No out-of-date medicines were found following a check of twenty randomly selected medicines. The team members used alert stickers to help identify medicines that were expiring within the next six months. They 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. And the team had access to CD destruction kits.

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 some training on how to follow the directive. The team members were 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 checked and recorded the fridge temperature each day. And a sample seen was within the correct range. The CD cabinet was secured and of an appropriate size. The medicines inside the fridge and CD cabinet were well organised.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy's equipment is well maintained and appropriate for the services it provides. The pharmacy uses its equipment to protect people's confidentiality.

Inspector's evidence

The pharmacy had reference resources including 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 fridges used to store medicines were of an appropriate size. 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 unauthorised 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.