General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Well, The Wilmslow Health Centre, Chapel Lane, WILMSLOW, Cheshire, SK9 5HX

Pharmacy reference: 1029877

Type of pharmacy: Community

Date of inspection: 15/08/2019

Pharmacy context

This is a community pharmacy inside a GP surgery in village of Wilmslow, 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), a substance misuse service and the NHS New Medicines Service (NMS). 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 access its services. It keeps the records it must have by law and keeps people's private information safe. 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 team members discuss errors they make whilst dispensing to learn from them. And they take steps to make sure the errors are not repeated.

Inspector's evidence

The pharmacy had a small open plan retail area which was next to the surgery waiting room. The pharmacy counter provided a barrier between the retail area and the dispensary. It had a private consultation room to the side of the pharmacy counter. The responsible pharmacist used the bench closest to the pharmacy counter to do final checks on prescriptions. This helped him 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 they were held electronically. The pharmacy's superintendent pharmacist's office 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 pharmacy had a process to report and 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. 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. The near miss errors were analysed each month for any trends and patterns. And the findings were discussed with the team in a monthly team meeting. The team members had made several changes to prevent errors happening again. This included the team discussing the importance of dispensing and checking off the prescription and not the computer-generated labels. The pharmacy documented the details of the analysis for future reference. It 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 incorrectly mixed up levothyroxine with a medicine with a similar strength. The team decided to store levothyroxine under 'T' instead of 'L' to help ensure it was always selected correctly.

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. The pharmacy collected feedback from people through an annual survey and mystery shopper visits.

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 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 Medikinet 10mg 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 explained how they stored and protected people's information via a poster displayed in the retail area. 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 system.

All the team members had completed training on safeguarding vulnerable adults and children via the online training system. And the regular pharmacist 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 they said they would discuss their concerns with the pharmacist on duty, at the earliest opportunity. The team members had no guidance readily available to them to help them properly manage and report a potential concern. But they did have the contact details of the local safeguarding teams. And they said that they would contact the local safeguarding teams for advice if they had any concerns. The team had recently raised a concern about a person's mental health with the adjacent GP surgery team.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough team members to manage the services it provides. It reviews staffing levels to ensure they remain appropriate. 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 implement 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 the regular pharmacist, a full-time pharmacy technician and two pharmacy assistants. A part-time pharmacy assistant and a delivery driver 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 pharmacist explained that 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 she preferred to complete the modules in her own time, without any distractions. The team member showed she had completed 99 percent of 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. They could give feedback on how to improve the pharmacy's services. And discuss their personal development. But the team was not able to provide any examples.

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. A team member had recently created an information leaflet which outlined how some people's prescriptions were dispensed at the company's offsite dispensing hub.

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 services and prescription volume. The team did not feel under pressure to achieve them.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is 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 benches in the main area of dispensary were cluttered but this improved as the inspection progressed. A segregated area to the side of the main dispensary area was particularly untidy. This was discussed with the team. Floor spaces were generally clear with no trip hazards evident. 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 takes suitable measures to identify risks when it changes its ways of working, such as dispensing at the company's offsite dispensing hub. The pharmacy sources its medicines from licenced suppliers. And it stores and generally manages its medicines appropriately. The pharmacy team members mostly complete checks on the expiry dates of medicines. And they highlight medicines with a short expiry date. But they do not always remove these medicines from use, before expiry. So, there is a possibility these may be supplied to people.

Inspector's evidence

The pharmacy was accessible through the main area of the GP surgery and from the surgery car park. The pharmacy had signage externally and in the GP surgery waiting area. 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 and in the GP surgery waiting area. Seating was provided for people waiting for prescriptions. A hearing loop was available to help people with a hearing impairment.

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. And so, an 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 recently 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 such as medicine use reviews. Each team member 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 dispensed via dispensing robots. It took three days for prescriptions to be processed and the medicines to be received from the hub. 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. The pharmacist had begun completing a quality assurance audit of the first 300 prescriptions that were dispensed and returned to the pharmacy via the hub. The pharmacist physically opened the sealed bags and completed a check of all the medicines. No errors had been identified so far.

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. The team members had access to methotrexate book, anticoagulant books and steroid cards to provide to people. They were aware of the pregnancy prevention programme for people who were prescribed valproate. The team said they were aware 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 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. No people had been identified. 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 team was required to check the expiry dates of the medicines on a three-monthly cycle. And some records of the checks were seen. But the team members had not always kept to the schedule due to time constraints. The pharmacy used stickers to highlight stock that was within six months of expiring. But the pharmacy team members didn't always take these medicines off the shelves when they had expired. And although the pack was highlighted there was still a risk these medicines could be supplied to people. This was discussed with the team members. And they agreed to make following the date checking process a priority. 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 be 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 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 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 them dispense multi-compartmental compliance packs. 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.