General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Well, The Health Centre, Victoria Road, HARTLEPOOL, Cleveland, TS26 8DB

Pharmacy reference: 1029922

Type of pharmacy: Community

Date of inspection: 29/02/2024

Pharmacy context

The pharmacy is in a busy health centre in Hartlepool town centre. It dispenses NHS prescriptions and provides medicines to some people in multi-compartment compliance packs. Pharmacy team members sell a range of over-the-counter medicines and provide services such as the NHS Pharmacy First service. And they deliver medicines to people's homes.

Overall inspection outcome

Standards not all met

Required Action: Improvement Action Plan

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 not all met	1.1	Standard not met	The pharmacy does not always adequately manage risks. Pharmacy team members work under pressure and don't always work in the safest way. And they do not fully complete some key tasks, such as properly managing medicines, which increases the risk of errors.
		1.2	Standard not met	Pharmacy team members do not record or fully discuss their mistakes. And they do not routinely make changes to help improve the quality and safety of services in response to the errors they make.
2. Staff	Standards not all met	2.1	Standard not met	The pharmacy does not always have enough team members to safely provide its services. Team members work under pressure and do not complete all necessary tasks in a safe and timely manner.
3. Premises	Standards not all met	3.1	Standard not met	The pharmacy is excessively cluttered and untidy. This increases the risk of team members making mistakes when dispensing people's medicines. And of team members tripping and falling while working.
4. Services, including medicines management	Standards not all met	4.3	Standard not met	The pharmacy does not manage and store all its medicines as it should. It has inadequate date checking processes. It stores a significant number of medicines in crates rather than on the shelves. And team members do not store medicines transferred from original manufacturer's packs in a safe way. This increases the risk of errors.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance **Standards not all met**

Summary findings

The pharmacy does not always adequately manage risks with its services. And team members do not record and effectively learn from the errors they make. They understand their role to help protect vulnerable people. And they suitably protect people's confidential information. The pharmacy keeps most of the records required by law. But some of these records are incomplete and inaccurate.

Inspector's evidence

The pharmacy had a set of standard operating procedures (SOPs) to help pharmacy team members manage the risks with its services. These were available electronically, and team members knew how to access them. The superintendent pharmacist's (SI) office reviewed the procedures every two years on a monthly rolling cycle. It sent new and updated procedures to pharmacy team members via its online training system. Team members read the procedures, and they completed a test after reading each one. They were required to pass the test before they could complete the sign off process on their learning record and confirm they had understood the process.

The pharmacy had recently started to provide the NHS Pharmacy First service for people. Pharmacy team members explained how the pharmacy had considered some of the risks of providing the service, such as the suitability of the pharmacy's consultation room to deliver the service from. And ensured they had stock of the relevant medicines and the availability of the necessary equipment. They also ensured they had completed the necessary training and had the correct SOPs and supporting documents in place. The manager explained the service was already popular, with the pharmacy currently completing up to six consultations a day. Team members explained they were struggling to manage the workload while the pharmacist was carrying out consultations with people. The manager also explained that due to current staffing pressures, they were unable to use their skills as an accuracy checking dispenser (ACD) as they were dispensing a significant proportion of the pharmacy's prescriptions, and so not able to carry out the final accuracy checks of these prescriptions. This increased the pressure on the pharmacist because following consultations, they had people waiting for their prescriptions to be checked.

The pharmacy had an SOP instructing team members how to highlight and record errors identified before people received their medicines, known as near miss errors. But team members were not currently recording these errors. And they explained they had not done so for several months. The regular pharmacist had left in August 2023 and team members explained there was a backlog of work, which meant the recording of errors had stopped. They could not demonstrate any changes to help improve safety after errors were made, other than highlighting to each other that an error had been made and trying to be more careful. During the inspection, team members were constantly being distracted from their dispensing activities to help resolve queries from people at the pharmacy counter and, most notably, to answer the telephone. This increased the risks of team members making mistakes. The pharmacy had a process for dealing with dispensing errors, which were mistakes identified after prescriptions had been handed out to people. Pharmacy team members recorded incidents using an online reporting system. The most recent record available was from April 2023, and gave details of what had happened. But there was little information captured about reasons why the mistake had happened and what the team had changed to improve safety.

The pharmacy had a procedure for complaint handling and reporting. It had a leaflet available for customers in the retail area which clearly explained the company's complaints procedure. It collected feedback from people verbally. And team members explained they were currently receiving frequent negative feedback, mainly about how long it took them to respond to people waiting at the pharmacy counter. And about how long it took the team to dispense people's prescriptions.

The pharmacy had current professional indemnity insurance. The pharmacy kept controlled drug (CD) registers electronically. It kept running balances for all registers, and the pharmacy's documented procedure required team members to audit these balances each week. The most recent audit was in January 2024, but did not include all CD registers. Before that, audits had been completed in December 2023 and October 2023. The inspector checked the running balances against the physical stock for three products. And two were found to be incorrect. The pharmacy kept an electronic register of CDs returned by people for destruction. It maintained a responsible pharmacist record electronically, and it was complete and up to date. The pharmacist displayed their responsible pharmacist notice. The pharmacy kept private prescription records in a paper register. Five prescriptions were found, dating from 26 June 2023 to the 27 October 2023, that had not been recorded in the private prescription register.

The pharmacy kept sensitive information and materials in restricted areas. It collected confidential waste in dedicated bins, which were periodically emptied by a waste disposal contractor for secure destruction. The pharmacy had a documented procedure to help pharmacy team members manage sensitive information. Pharmacy team members completed mandatory assessments to confirm they had understood the procedure. And they completed mandatory confidentiality and information security training each year. Team members explained how important it was to protect people's privacy and how they would protect confidentiality.

The pharmacy had procedures for dealing with concerns about children and vulnerable adults. Pharmacy team members completed mandatory safeguarding training every two years. They gave some examples of signs that would raise their concerns about vulnerable children and adults. And how they would refer their concerns to the pharmacist, area manager, or seek advice from colleagues at another local branch. They also explained how they would use the internet to find information about how to report their concerns to local safeguarding teams.

Principle 2 - Staffing **Standards not all met**

Summary findings

The pharmacy does not always have enough team members to manage the pharmacy's workload. And team members do not complete all necessary tasks properly. This increases the risks of them making mistakes. Pharmacy team members generally complete ongoing training to keep their knowledge and skills up to date. But this is outside of working hours. Team members know how to raise concerns about the pharmacy. But they are not always confident they are fully resolved.

Inspector's evidence

The pharmacy's manager had left in August 2023 and different locum pharmacists were acting as the RP. The pharmacy had two qualified part-time dispensers and two part-time delivery drivers. One dispenser was soon reducing their working hours. And no plans had been discussed to replace the hours they were not working. The pharmacy employed a further part-time dispenser, but they were currently on long term absence, which had not been covered. The company had recently provided the pharmacy with a locum dispenser who worked at the pharmacy four or five days a week. But this was subject to their availability. Since October 2023, one part-time pharmacy technician and two full-time dispensers had also left and had not been replaced.

Team members were seen to be working under pressure and were behind with the workload. There were tasks such as CD balance checks, checking expiry dates of medicines, putting stock away on shelves and tidying that were not completed regularly. They were not utilising the skills of the team members. The ACD dispensed many prescriptions, which meant they could not carry out the final accuracy check. And team members were not processing prescriptions on the system to allow some of the workload to be dispensed at the company's offsite hub pharmacy.

Pharmacy team members, when possible, completed mandatory e-learning modules issued by head office, which included any new or updated standard operating procedures. Some recent examples included training about the NHS Pharmacy First service and security awareness. Team members explained that they did not have time to complete training and read updated SOPs during working hours, despite having allocated training time provided. So, they completed this in their own time at home. But this was difficult for some. The company had an appraisal process in place. But team members could not remember the last time they received an appraisal.

Team members explained how they had raised several concerns with senior managers about how they were struggling to keep up with their workload and demands for pharmacy services. There had been the provision of a locum dispenser to help, but overall team members were disappointed with the level of support. Recently, the pharmacy had operated with a pharmacist and one dispenser for a day, which resulted in closure of the pharmacy over lunch. The pharmacy had received an internal audit in January 2024, with action points, but had received no feedback about how to improve.

The pharmacy had a whistleblowing policy. And pharmacy team members knew how to access the procedure if necessary. Pharmacy team members communicated with an open working dialogue during the inspection. The team had targets to achieve in various areas of the business. But they explained how currently, they were consistently unable to meet the targets, and were concentrating on providing people with core services such as dispensing and the NHS Pharmacy First service.

Principle 3 - Premises **Standards not all met**

Summary findings

The pharmacy is generally suitable for the services provided. But the area where team members dispense prescriptions is untidy and cluttered. There is a significant risk of the team tripping and falling over items stored on the floor. And the pharmacy has cluttered and untidy shelves, introducing increased risk of team members making mistakes whilst dispensing. The pharmacy is clean and secure. And it has a room where people can speak to pharmacy team members privately.

Inspector's evidence

The dispensing area in the pharmacy was cluttered. Most of the pharmacy's bench space was taken up with stacks of baskets of dispensed medicines. And several wholesaler crates containing stock were kept on the floor, significantly increasing the risk of trip hazards. The shelves where medicines were stored were generally cluttered and untidy, increasing the risk of picking the incorrect medicine. There was a clearly defined checking area for pharmacist to use. But this was also cluttered with baskets containing prescriptions at various stages of the dispensing process.

The rest of the pharmacy was clean and well maintained. The retail area was tidy and well organised. The pharmacy had a private consultation room available. Team members used the room to have private conversations with people. The room was 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, with a sink which provided hot and cold running water and other facilities for hand washing. Heat and light in the pharmacy was maintained to acceptable levels. Team members prevented unauthorised access to restricted area of the pharmacy.

Principle 4 - Services **Standards not all met**

Summary findings

The pharmacy sources its medicines from reputable suppliers. But it does not store and manage all its medicines appropriately. The pharmacy does not have a robust process for checking the expiry date on medicines. And this increases the risk of people receiving medicines that are out of date. Overall, the pharmacy suitably manages its dispensing services. And team members provide people with some advice and information about taking higher-risk medicines.

Inspector's evidence

The pharmacy had level access from the street and the surgery reception area. Pharmacy team members explained how they would communicate in writing with people with a hearing impairment. And provide large-print labels and instruction sheets to help people with a visual impairment.

The pharmacy had access to the company's off-site dispensing hub pharmacy, where they could send prescriptions to be dispensed to help ease their workload. But the team were not utilising this resource. They explained how difficult it was to find the opportunity during the day to process the prescriptions to send to the hub. They also explained that locum pharmacists often did not have the correct credentials to be able to use the company's hub system. This meant that team members had to dispense these prescriptions locally, adding to their workload.

The pharmacy had a documented SOP for managing the expiry dates of medicines. But team members weren't following the SOP. They explained they currently did not have capacity to complete regular expiry date checks. And they could not remember the last time a full check had been completed. There were no records of any previous checks available during the inspection. Team members explained they looked at expiry dates when they dispensed medicines. But the pharmacist explained they had rejected medicines during their final checks because the medicine was out of date. After a search of the shelves, the inspector found twelve medicines that had expired, with expiry dates ranging from November 2022 to November 2023.

Several plain white medicine boxes were found on the shelves in the dispensary. These boxes contained mixed batches of medicines that had been removed from their original packaging. They did not have labels attached with information about the batch number or expiry date of the medicines inside. This meant that there was a risk that these medicines may be supplied to people after they had expired or after they had been recalled by the manufacturer. One example was a box containing mixed batches of pregabalin 200mg capsules. Two of the strips showed an expiry date of December 2023. Another example was a box which had a partial dispensing label attached. Team members explained the box had been returned to the shelves as the prescription had not been collected. The label described the contents as promethazine 10mg tablets and did not display a batch number or expiry date. Inside the carton were mixed batches of promethazine. And one of the strips contained promethazine 25mg tablets, which had been placed in the incorrect container.

The shelves in the pharmacy where medicines were stored were generally cluttered and untidy. There were several shelves where stacks of different medicines, or different strengths and formulations of the same medicines, had fallen and become mixed together, significantly increasing the risk of errors. Team members explained how they had not had opportunities to tidy and reorganise the shelves. There were

several large crates stored on the floor in various places around the pharmacy. Team members explained they contained split packs of medicines that had been used during dispensing, or stock that had arrived, which they had not had time to put away on the shelves. They explained that some of the split packs particularly had been accumulating in these crates for months.

Pharmacy team members signed the 'dispensed by' and 'checked by' boxes on dispensing labels during dispensing. This was to maintain an audit trail of the people involved in the dispensing process. They used dispensing baskets throughout the dispensing process to help prevent prescriptions being mixed up. The pharmacist counselled people receiving prescriptions for valproate if they were at risk. And they checked if the person was aware of the risks if they became pregnant while taking the medicine. They checked if they were on a pregnancy prevention programme and taking regular effective contraception. And team members were aware of the requirements to dispense valproate in the manufacturer's original packs. The pharmacy supplied medicines to a significant number of people in multi-compartment compliance packs when requested. It attached backing sheets to the packs, so people had written instructions of how to take their medicines. And team members included descriptions of what the medicines looked like, so they could be easily identified in the pack. They provided people with patient information leaflets about their medicines each month. Team members documented any changes to medicines provided in packs on the person's master record sheet, which was a record of all their medicines and where they were placed in the packs. And they recorded changes on their electronic patient medication record (PMR). During the inspection, the team member preparing packs was continually interrupted from their task to answer the telephone, respond to queries from colleagues and complete other tasks being asked of them. They acknowledged mistakes had been made, but had not been documented.

The pharmacy obtained medicines from licensed wholesalers. It had disposal facilities available for unwanted medicines, including CDs. Team members monitored the minimum and maximum temperatures in three pharmacy fridges each day and recorded their findings. The temperature records seen were within acceptable limits. The pharmacy delivered medicines to people via a delivery driver, who also delivered medicines for other local pharmacies within the same company. The pharmacy used an electronic system to manage and record deliveries and it uploaded information to the driver's handheld device. Team members highlighted bags containing controlled drugs (CDs) on the driver's device and on the prescription bag. The delivery driver left a card through the letterbox if people were not at home when they attempted delivery, asking them to contact the pharmacy. And they returned the medicines to the pharmacy.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the necessary equipment available for the services it provides. It manages and uses its equipment in ways that protect people's confidentiality.

Inspector's evidence

The pharmacy had the equipment it needed to provide the services offered. The resources it had available included the British National Formulary (BNF), the BNF for Children, various pharmacy reference texts and use of the internet. The pharmacy had a set of clean, well-maintained, standardised measures available for liquid medicines preparation. It had suitable containers available to collect and segregate its confidential waste. It kept its password-protected computer terminals and bags of medicines waiting to be collected in the secure areas of the pharmacy, away from public view.

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.