General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Well, Berwick Hills Centre, Ormesby Road, MIDDLESBROUGH, Cleveland, TS3 7RP

Pharmacy reference: 1029961

Type of pharmacy: Community

Date of inspection: 18/03/2024

Pharmacy context

The pharmacy is part of a local shopping and community centre complex in Middlesbrough. It changed ownership in November 2023. The pharmacy's main services include dispensing NHS prescriptions and selling over-the-counter medicines. It provides substance misuse services to people. And it offers people the option to collect their medicines through an automated collection point situated to the side of the premises. The pharmacy offers a medicine delivery service to people.

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 adequately identify and address the risks for the services it provides. Pharmacy team members do not always follow the pharmacy's written procedures and they do not always follow safe working practices.
		1.2	Standard not met	The pharmacy does not promote an open culture of learning from mistakes. Pharmacy team members cannot demonstrate adequate learning from these types of events.
2. Staff	Standards not all met	2.2	Standard not met	Pharmacy team members have not completed adequate training associated with the pharmacy's processes. And one team member has not been enrolled on a GPhC accredited training course within the time frame required.
3. Premises	Standards met	N/A	N/A	N/A
4. Services, including medicines management	Standards not all met	4.2	Standard not met	The pharmacy’s intermittent internet connectivity is causing a backlog of work and is comprising the team’s ability to manage the pharmacy’s dispensing services safely. The placement of the pharmacy's automated collection point on registered premises means people can collect their medicine from the pharmacy when a responsible pharmacist is not present.
		4.4	Standard not met	The pharmacy does not suitably respond to concerns about the safety of medicines and medical devices, such as drug recalls.
5. Equipment and facilities	Standards not all met	5.1	Standard not met	The pharmacy’s intermittent internet activity compromises the safe and effective delivery of its services.

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

Summary findings

The pharmacy does not routinely assess key risks for the services it provides. Pharmacy team members do not always follow the pharmacy's written procedures. And they are not familiar with processes designed to monitor risk and to share learning following mistakes they make during the dispensing process. Pharmacy team members understand how to respond to feedback. They know what steps to take to help keep vulnerable people safe from harm. And they keep people's confidential information secure.

Inspector's evidence

The pharmacy transferred ownership in November 2023. Since this date team members reported experiencing regular disruption to pharmacy services caused by intermittent issues with internet connectivity. The problems meant the pharmacy was unable to download prescriptions for several hours at a time. Team members reported that this was happening several times a week and, on some occasions, had happened more than once in the same day. The pharmacy team was experiencing an acute rise in violence and aggression towards its team members. Team members felt this was due to delays in the dispensing process and increased waiting times caused by the ongoing internet issues. The pharmacy operated a zero-tolerance approach to verbal and physical abuse of its team members. And the owners were actively addressing current risks to safety. It had acted to employ a security guard to monitor access into and out of the pharmacy and it had developed an action plan of other steps it was taking to protect staff safety. Team members understood the need to report threats and acts of violence and aggression towards them and knew to contact the emergency services to seek immediate support should a situation escalate.

The pharmacy had standard operating procedures (SOPs), designed to support its safe and effective running available for team members to refer to. But not all team members were familiar with how to access these and not all team members had completed learning to support them in carrying out tasks in accordance with the SOPs. Observations showed team members did not always work in accordance with the SOPs. For example, not all team members were aware of how to safely handle patient-returned medicines. The pharmacy provided people with the option to collect their medicines through an automated collection point at the side of the pharmacy premises. Team members were aware that medicines requiring cold storage and controlled drugs could not be collected via the collection point. But they were not aware of any SOP or risk assessment to support them in supplying medicines in this way.

Pharmacy team members explained how they recorded some of the mistakes they made and identified during the dispensing process, known as near misses. But near miss records were not available for inspection despite significant efforts made by team members to locate paper records. The pharmacy manager had recently completed learning to support them in completing near miss records electronically and there was one near miss record waiting to be completed in this way. The pharmacy team was aware of the need to report mistakes identified following the supply of a medicine to a person, known as dispensing incidents. Team members did not know how to make these records available for inspection to demonstrate how they were learning from these types of mistakes. And they had not taken the opportunity to review near miss and incident records to check for patterns in their

mistakes to help inform any risk reduction actions required.

Pharmacy team members knew how to manage feedback and concerns. And understood how to refer a person to the pharmacy's head office should a person wish to escalate their concern. Some team members had completed learning about safeguarding vulnerable people. And there was some information available to team members to support them in reporting these types of concerns. Pharmacy team members understood the importance of keeping people's confidential information secure. The pharmacy held all personal identifiable information in staff only areas and it had appropriate arrangements for disposing of its confidential waste securely.

The pharmacy had current indemnity insurance. The RP notice displayed the correct details of the RP on duty. The RP record had recent gaps where pharmacists had not made an entry into the record. This meant it was difficult for the pharmacy to show who had been responsible on these days. Pharmacy team members were not aware of how they would record the supply of an unlicensed medicine. The most recent completed records for the supply of an unlicensed medicines presented for inspection had been made in July 2022. Entries in the private prescription register were completed in full. The pharmacy maintained running balances in its controlled drug (CD) register. It held this register electronically. And the team completed regular balance checks of physical stock against the register. A random balance check carried out during the inspection matched the balance recorded in the register. The pharmacy kept a register of CDs returned by people for destruction.

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

Summary findings

Pharmacy team members have not received appropriate training on the pharmacy's processes to support them in delivering its services safely and effectively. Whilst the pharmacy employs enough team members, this lack of learning contributes to workplace pressures. Pharmacy team members understand how they can raise a concern at work, and they are supportive of each other.

Inspector's evidence

The pharmacy did not employ a regular pharmacist. The RP on duty was a locum pharmacist working their first shift in the pharmacy. They were experienced with the company's processes, and they were observed supporting other team members in accessing information and completing tasks during the inspection. On duty alongside the RP was the pharmacy manager (a qualified dispenser), three other qualified dispensers, a medicine counter assistant, and a trainee team member. One of the qualified dispensers was a locum, they were not familiar with the pharmacy's patient medication record (PMR) system. As such they were working to support the team by completing tasks they were familiar with such as unpacking the medicine order and assembling medicines during the dispensing process. A company-employed delivery driver provided the medicine delivery service. The pharmacy also employed another qualified dispenser and a trainee dispenser.

Pharmacy team members did not receive protected learning time at work. And not all team members had completed core learning to support them in their roles, such as reading and understanding the pharmacy's SOPs. The company had provided some learning sessions when it had taken ownership of the pharmacy. But not all team members had been present during these sessions. A team member explained this meant they had to try to fit in learning as team members came to complete tasks they were unfamiliar with. This approach put extra strain on a team that was already experiencing pressure. A trainee team member had been working at the pharmacy since November 2023. They stated they had completed 'on the job' training and had not yet read the pharmacy's SOPs. This team member had not been enrolled on a GPhC accredited learning course as required.

The pharmacy had a whistleblowing policy and team members knew how they could raise concerns and provide feedback at work. The team was being supported by its area operations manager and regional operations manager. And team members were aware of some of the changes being made to improve their safety and wellbeing at work. Team members worked well together and were seen to support each other whilst working. They engaged in regular conversations about workload to support them in providing the pharmacy's services. Targets for services had not been discussed with the RP. The RP was observed applying their professional judgment when providing services and took time to speak to people visiting the pharmacy and to support team members.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are secure and maintained to an adequate standard. They include suitable private consultation spaces. Overall, they provide a suitable environment for providing pharmacy services.

Inspector's evidence

The pharmacy was adequately maintained, and it was secure. It was generally clean and spacious. But some areas of the pharmacy, particularly in the dispensary were disorganised. For example, the team held some baskets containing medicines on the dispensary floor. Team members had pushed the baskets against a centre island to reduce the risk of them causing a trip hazard. Lighting and ventilation arrangements throughout the premises were sufficient. Team members had access to appropriate hand washing facilities. The team reported that the automated collection point got particularly hot during summer months. They explained the pharmacy's previous owners had fitted fans within the machine to manage this. The position of the machine meant the screen and touchpad were exposed to the full heat of the sun during some of the day, and as such may get very hot.

The public area of the pharmacy was a good size and provided seating for people waiting for pharmacy services. The pharmacy had two signposted consultation rooms off this area. One room led to a hatch and provided privacy to people attending the pharmacy for some of its services. Another room provided space for consultation services. This room was fitted with a desk and chairs but was somewhat cluttered. For example, a number of sharps bins were stored in the room. The dispensary was fitted with ample workbench space although some of this space was taken up with paperwork and baskets of prescriptions and medicines waiting to be processed. Team members had sufficient space for completing dispensing tasks safely and the RP had dedicated bench space at the front of the dispensary. A door leading from the back of the pharmacy led to staff facilities, including a break room.

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

Summary findings

The pharmacy does not have appropriate controls to support its team members in effectively managing its services. Its intermittent internet connectivity is causing a backlog of work which is compromising the safety of its dispensing services. Pharmacy members are not familiar with processes for receiving and responding to medicine safety alerts. So, there is a risk people may receive medicines that are not safe to take. The pharmacy obtains its medicines from reputable suppliers. And it adequately manages the storage of its medicines.

Inspector's evidence

People accessed the pharmacy from street level. The pharmacy advertised its opening hours and details of the services it provided. It advertised a new policy designed to limit access to six people in the public area at any given time. And a security guard monitored access into the pharmacy to ensure this process was followed. The pharmacy protected Pharmacy (P) medicines from self-selection by displaying these behind the medicine counter. The RP was able to supervise the activity taking place in the public area from the dispensary. And they were observed intervening when their attention was required at the medicine counter.

A team member demonstrated the process for transferring medicines into the pharmacy's automated collection point. The pharmacy had obtained consent before supplying medicines in this way and had processes to monitor the collections from the machine. It used a text messaging service to inform people of their personal code in order for them to collect their medication. But team members explained that often people complained about not receiving these codes and this meant they needed to attend the pharmacy to pick up their medicines after they had been placed in the machine. This meant team members had to open the machine to retrieve the medicine. Team members explained this process was timely and it took the machine around 15 minutes to reset every time they did this. The automated collection point was accessible to people 24 hours a day over seven days of the week. It was located within the registered pharmacy premises footprint. This meant a pharmacist was required to be present to supervise the collection of assembled medicines from the machine at all times. And this was not the case as pharmacists were only present during the pharmacy's opening hours.

Pharmacy team members used baskets throughout the dispensing process to help keep all items for each prescription together. They took ownership of their work by signing their initials on dispensing labels to confirm their involvement in the dispensing process. The pharmacy retained prescriptions for the medicines it owed to people when the full quantity of a medicine could not be supplied. But it did not have an efficient process for managing the timely dispensing of these medicines. This meant people returning to the pharmacy to collect the remainder of their medicines were kept waiting as owings were not processed as stock arrived. This also risked medicines not being available to fill the owings when people returned. There were some delays in people receiving their medicines due to the intermittent internet connectivity, and there was a queue of people outside the pharmacy waiting to access services during the inspection. This put the team under pressure and meant they didn't work in the most organised and safe way.

Pharmacy team members transcribed information from prescriptions to an automated dispensing machine prior to the supply of substance misuse medicines. Pharmacists were required to complete a clinical and final accuracy check of the medicine against the prescription at the point of dispensing. Team members explained they would refer prescriptions for valproate to the RP. The RP had suitable knowledge of the checks required when supplying valproate to people requiring a pregnancy prevention plan. The team did not routinely record counselling and the interventions it made when supplying medicines on people's medication records to help support continual care.

The pharmacy sent some prescription information to the company's offsite dispensing hub pharmacy. Team members understood the process for managing this service safely. They explained there had been a few delays in being able to transmit data to the hub pharmacy due to the intermittent internet problems. But generally, the service was working well. The process involved pharmacists completing data accuracy and clinical checks of prescriptions prior to transmitting data to the hub pharmacy. Some prescriptions were part-dispensed locally and part-dispensed by the offsite dispensing hub pharmacy. And a team member demonstrated an efficient process for managing these prescriptions. The pharmacy used a digital application to support it in delivering medicines to people. And drivers had received appropriate training and guidance to support them in delivering medicines to people safely. But team members in the pharmacy were not aware of how to access delivery records to support them in managing queries about the delivery service.

The pharmacy sourced medicines from licensed wholesalers. It stored medicines in their original packaging. Some boxes of medicines in one area of the dispensary had fallen from shelves onto the floor in a corner of the dispensary. The pharmacy stored its CD medicines safely in secure cabinets. It stored medicines neatly inside these cabinets with out-of-date medicines and patient-returned medicines clearly separated. The pharmacy's fridge was a suitable size for the medicines it held. But there were no recent records available to show the team was monitoring the operating temperature of the fridge. The last records of temperature checks were from January 2024. The minimum and maximum readings on the fridge thermometer showed the fridge had been operating within the required temperature range of two and eight degrees Celsius during the inspection. Pharmacy team members had not carried out physical expiry-date checks of the pharmacy's stock for some months. To reduce the risk of supplying an out-of-date medicine they routinely checked expiry dates during the dispensing process. Random checks of stock in the dispensary found a number of out-of-date medicines. These were removed from the shelves and brought to the attention of team members.

The pharmacy had medicine waste receptacles available to support it in disposing of out-of-date medicines and patient returns safely. Pharmacy team members were not aware of the process for checking and responding to medicine alerts and drug recalls. They explained they were not aware of any recent alerts being brought to their attention.

Principle 5 - Equipment and facilities **Standards not all met**

Summary findings

The pharmacy does not have adequate internet facilities. And it does not consider the equipment and resources required to support its contingency plans for providing its services. Its team members act with care by using the pharmacy's facilities and equipment in a way which protects people's confidentiality.

Inspector's evidence

The pharmacy had some reference resources available. These included access to a hardcopy of the British National Formulary (BNF). Pharmacy team members access to people's medication records was through password protected and most team members had their own NHS smart card. Information on computer monitors was suitably protected from unauthorised view. The pharmacy stored bags of assembled medicines on shelves to the side of the dispensary. These storage arrangements protected confidential information on bag labels from public view.

The pharmacy had a range of equipment to support it in delivering its services. It checked this equipment regularly. For example, team members calibrated the automated dispensing machine daily. And they used appropriately CE marked measures to check the volume dispensed against the amount the machine was instructed to deliver. Pharmacy team members reported that access to the internet was intermittent and slow. The team reported internet outages were occurring a few times a week for several hours at a time, and sometimes multiple times in one day. These internet outages meant the team was unable to download prescriptions from the NHS spine. A complete outage of the pharmacy's PMR system had seen pharmacy team members refer people to their surgery to obtain paper prescriptions on a recent occasion. The team had handwritten medicine labels when supplying some medicines. But it had not considered the risks of providing services in this way, such as reviewing the need to apply cautionary warnings to medicine labels when dispensing medicines.

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.