General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Well, 1-3 Station Road, Silloth, CARLISLE, Cumbria, CA7 4AE

Pharmacy reference: 1030182

Type of pharmacy: Community

Date of inspection: 18/07/2019

Pharmacy context

This is a community pharmacy in the village of Silloth, Carlisle. 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), flu vaccinations, a substance misuse service and the NHS New Medicines Service (NMS). It also supplies medicines in multi-compartmental compliance packs to people living in their own homes and three local care 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 met	N/A	N/A	N/A
2. Staff	Standards not all met	2.1	Standard not met	The pharmacy is undergoing significant changes in its processes. And the pharmacy has recently had staff changes. The team members are struggling to complete the workload effectively and in a timely manner. The pharmacy team doesn't have a robust contingency plan when it falls behind on its tasks. This increases the pressure on the team and may impact people using the pharmacy's services.
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 processes and up-to-date procedures to help the team manage the risks to services. And it keeps the records it must by law. It advertises how people can provide feedback and raise concerns. The pharmacy keeps people's private information safe, and the pharmacy team members are trained to safeguard the welfare of vulnerable adults and children. They discuss near-miss errors when they happen and sometimes make a record. So, they may miss opportunities to learn from them.

Inspector's evidence

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. But the team members did not regularly record their errors. And so, they may have missed out on some learning opportunities. They said that they did not always record their errors because of a lack of time to do so. The team members said they previously analysed their near misses for any trends and patterns. And documented and discussed the findings in a monthly patient safety meeting. The document was then to be affixed onto a dispensary wall. So, they team could easily access it. But the team had not carried out the analysis for several months. And the latest patient safety report displayed was from July 2018. The team members had ad-hoc, informal discussions whenever a significant near miss error happened. And they quickly discussed how they could prevent the error from happening again. To reduce the risk of errors the team had separated some medicines on its shelves that sounded or looked similar. But the team could not demonstrate any examples. The pharmacy had a process to record dispensing errors that had been given out to people. It recorded these incidents on Datix. A copy of the report was sent to the superintendent pharmacist's office for analysis. The team members said they were vaguely aware of an incident that had occurred within the last twelve months. But they were unable to demonstrate how they had learned from the incident and reduced the risk of further errors happening.

The pharmacy had a poster on display which advertised how people could make comments, suggestions and complaints. It contained the company head office address, email and telephone number. The pharmacy collected feedback from people through an annual survey and mystery shopper visits. But the team members were unsure of the outcomes them. And so, they could not demonstrate any improvements that had been implemented following any negative feedback.

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 any emergency supplies and unlicensed medicines. But the team members were unable to locate any

records of supplies against private prescriptions.

The pharmacy kept controlled drugs (CDs) registers. These were in order including completed headers, and entries made in chronological order. The pharmacy was required to check the running balances against physical stock each week. The team members were unable to find the time to do this, but the checks were carried out at least once a month. The running balance checks of three CDs were checked. But one of the three did not match. This was discussed with the pharmacist. The pharmacist managed to attribute the discrepancy to a delivery of CDs not being entered in the CD register on the day it had arrived.

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 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. 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 teams for advice if they had any concerns.

Principle 2 - Staffing Standards not all met

Summary findings

The pharmacy has staff with the right qualifications and skills for their roles. But it is undergoing significant changes in its processes. And there has been recent staff changes. The pharmacy team are struggling to complete the workload in an effective and timely manner. This increases the pressure on the team and may impact on the pharmacy's services. The pharmacy team members have access to ongoing learning opportunities. And they feel comfortable to raise any professional concerns thay may have.

Inspector's evidence

At the time of the inspection, the team members present were a locum pharmacist, a full-time pharmacy technician who was also the pharmacy manager, a full-time pharmacy assistant and a part-time accuracy checking technician (ACT). The pharmacy also employed three part-time pharmacy assistants who were not present during the inspection. The pharmacy did not have a regular pharmacist and had not had one for several months. A full-time pharmacist had been recruited and was due to start in August. The team members said that they were looking forward to them starting as they had felt some pressure working with various locum and relief pharmacists. The pharmacy manager had started her employment four weeks ago and was therefore relatively new to the business. In the past two weeks, the pharmacy had installed new dispensing software and it had been authorised to send many of its repeat prescriptions to be dispensed offsite by a dispensing robot. The team members said they were finding this period particularly challenging, especially using the new dispensing software. Posters were displayed in the retail area which explained to people that it may take the team longer to dispense their prescriptions because of the new software. The team members were looking forward to getting used to the new offsite dispensing system, as they felt it would help reduce their dispensing workload in time.

At the time of the inspection the pharmacy was busy with a constant flow of people coming into the premises and waiting while their prescriptions were being dispensed. There were several baskets containing medicines and dressings on the floor and in front of a rear exit door. Boxes of medicines that had been delivered in the morning had not been put away by late afternoon. The team members explained that they were about a day behind in their dispensing workload and this was relatively normal. The team was seen prioritising dispensing the prescriptions for people who wanted to wait while their prescriptions were dispensed. One of the team members was working on dispensing prescriptions for a care home. And the task was scheduled to be completed at the end of the next day (Friday) and to be delivered to the home on the upcoming Monday. But the pharmacy manager asked them to help with dispensing walk-in prescriptions as the waiting time was around 20-30 minutes. The team members were asked how this would affect the dispensing for the care home. They said that they would have one day less to dispense. The pharmacy manager said that she would come in to work on her day off to assist with the dispensing and ensure that the care home received its medicines on time. The team were seen working with an open dialogue and striving to ensure they provided the best service.

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. The team members said

that they always tried to make sure they were up to date with their training, but this was not always possible due to the dispensing workload. 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 were also able to give feedback on how to improve the pharmacy's services. And discuss their personal development. But the team members said it had been over a year since their last appraisal.

The team members said they were able to discuss any professional concerns with the 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 members said they were often unable to meet the targets. But they were not put under and pressure from the company do so.

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 the pharmacy has a room where people can speak to pharmacy team members privately.

Inspector's evidence

The pharmacy was clean and well maintained. The exterior and the retail area portrayed a highly professional image. The downstairs dispensary was small, and the benches were cluttered with various baskets and miscellaneous items. The floor of the dispensary was cluttered with baskets containing medicines awaiting a final check. This presented a trip hazard and the risk of stock from the shelves falling into the baskets and causing a potential dispensing error. There was a rear exit door. But the exit was obstructed with many baskets and bags containing dressings.

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. It was located next to a small corridor and not signposted. And so, people may not know there was a room available for them to have private conversations with the team. The temperature was comfortable throughout the inspection. Lighting was bright throughout the premises.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy is accessible to people and it provides services to support people's health needs. The pharmacy has robust procedures that the team members follow when they dispense medicines into multi-compartmental compliance packs. The pharmacy sources its medicines from licenced suppliers. And it generally stores and manages it medicines appropriately. It completes checks of the expiry dates of its medicines regularly, so it can make assurances its medicines are fit for purpose. But the pharmacy does not always check that the fridges are operating within the correct temperature ranges.

Inspector's evidence

The pharmacy was accessible via a small step in the street to a simple push/pull door. A ramp was available to help people with mobility issues enter the premises. 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 had a hearing induction loop for people who used a hearing aid. The pharmacy advertised its services and opening hours near the entrance. It also displayed contact details of other pharmacies in the local area. Seating was provided for people waiting for prescriptions. The pharmacy offered a delivery service, but this had recently been scaled down from operating five days a week to three days a week. The pharmacy manager was seen arranging a delivery for a person who required the medicines urgently on a day when the delivery service was not in operation.

The pharmacy team members regularly used various alert stickers during dispensing. The team member that handed out the medicines then used these stickers to complete any required tasks and to speak to people about any issues or to give any advice needed. 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. An audit trail was in place for dispensed medication using dispensed by and checked by signatures on labels. 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 didn't have a robust process to highlight the expiry date of CD prescriptions awaiting collection in the retrieval area. So, there was a risk of supplying CDs, that were not stored in the CD cabinet, after the prescription's expiry date. The importance of this was discussed with the pharmacist. 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 often 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. But details of these conversations were not recorded on people’s medication records. So, the pharmacy could not demonstrate how often these checks took place. INR levels were not always assessed in the pharmacy. The team 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 did a check to see if any of its regular patients were prescribed valproate. And met the requirements of the programme. But the team members were unsure of the results of the audit. The pharmacy used clear bags to store dispensed insulin. This allowed the team member and the person collection to undertake a final visual check of the medicine before the person collected the medicine.

The pharmacy supplied medicines in multi-compartmental compliance packs for people living in their own homes and living in three local care homes. And the pharmacy supplied the packs to people on either a weekly or monthly basis. The team members were responsible for ordering the person’s prescription. 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 team members recorded details of any changes, such as dosage increases and decreases, on the master sheets. They dispensed the packs in a first-floor room. This was to make sure they weren't distracted while dispensing. The packs had backing sheets. But the sheets did not contain information to help people visually identify the medicines. The team members said that they were not sure how to enter the information onto the new dispensing software. The team routinely provided patient information leaflets with the packs.

Pharmacy only medicines were stored behind the pharmacy counter. The storage arrangement prevented people from self-selecting these medicines. 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 the dispensary shelves. And no out-of-date stock was found during 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 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 used two fridges to store several medicines. The team kept the contents of the fridges clean and tidy. The fridges had thermometers installed to help them monitor the temperature ranges. But there were no records of the temperatures kept for one fridge. And there were no records for the other fridge for nine days in July 2019. The temperatures were checked during the inspection. And they were within the correct range. Without regular checks the pharmacy could not be certain medicines that needed to be stored in the fridge had been stored at the correct temperature.

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. And tweezers and rollers were available to help the team dispense multi-compartmental compliance packs. The fridges used to store medicines were of an appropriate size. And the medicines inside were organised in an orderly manner. All the electrical equipment looked in good condition and was working.

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.