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: 14/02/2020

Pharmacy context

This is a community pharmacy on a parade of shops in the town of Silloth, Carlisle. 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. It provides NHS services, such as the New Medicines Service (NMS) and medicines use reviews (MURs). The pharmacy supplies medicines in multi-compartment compliance packs to some people living in their own homes and some local care homes. 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	1.2	Good practice	The team members are good at recording, discussing and analysing any mistakes that happen within the dispensing process. They demonstrate how they learn from their mistakes. And how they implement changes to reduce the risk of mistakes happening again.
2. Staff	Good practice	2.2	Good practice	The pharmacy encourages and supports its team members with keeping their knowledge and skills up to date. And it supports their personal development. It achieves this by providing them with a structured training programme and regular appraisals.
		2.5	Good practice	The team members are encouraged to give feedback to improve the pharmacy's services. They feel comfortable to raise professional concerns with senior management. And the concerns are listened to and acted upon.
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. The team members are good at recording, discussing and analysing any mistakes that happen within the dispensing process. They demonstrate how they learn from their mistakes. And how they implement changes to reduce the risk of mistakes happening again.

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 pharmacist highlighted any near miss errors made by the team when dispensing. The team members recorded their own mistakes which helped with their learning. They entered the details of the near miss errors on to an online reporting system called Datix. They also discussed the errors made at the time, so all the team members present could be made aware of what went wrong. And what they could do to prevent a similar error happening again. The near miss errors were analysed each month by a team member and the findings were documented into a report. The team explained the main contributory factor to the pharmacy's near miss errors was due to untidy shelves caused by an over-ordering of stock. In November, the team spent some time reorganising the shelves and made changes to its ordering system to reduce the stock of medicines. The team members also demonstrated what they had done to prevent near miss errors involving medicines that looked or sounded similar, known as LASA medicines. The team had affixed alert stickers next to where they stored some of the LASA medicines that were most commonly involved in near miss errors. The purpose of the alert stickers was to remind the team to take more care when they were picking the LASA medicines from the shelves. The team members analysed the near misses to see if the stickers were serving their purpose. They had placed stickers next to amlodipine and atenolol, but they found they were still making errors. They discussed what they could do, and they decided to instead separate the two medicines away from each other. 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 pharmacy had recently made an error by dispensing the wrong strength of a medicine. The team members completed a root cause analysis and discussed ways they could stop a similar error happening again. It was established that the area where the medicine was stored was very untidy. The team members reorganised the shelves, as described above, to ensure they were kept tidy and the different strengths of the medicines were kept separate.

The pharmacy was not displaying the correct responsible pharmacist notice at the time of the inspection. So, people who used the pharmacy may not know the correct details of the responsible

pharmacist on duty. 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. But it was on display in the pharmacy's consultation room. So, it was not easily accessible to everyone who used the pharmacy. 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 team was unable to provide any example of any improvements made in response to any feedback.

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. It 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 week. 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). And they had completed training each year via the eExpert online training system. 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). She was due to complete refresher training in the next few months. The pharmacy manger had completed training through his work with the North West Ambulance Service. Other team members had not completed any formal training. 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 could telephone the pharmacy's superintendent's office.

Principle 2 - Staffing ✔ Good practice

Summary findings

The pharmacy team members have the appropriate qualifications and skills to provide the pharmacy's services safely and effectively. They work well together to manage their workload effectively and efficiently. The pharmacy encourages and supports its team members with keeping their knowledge and skills up to date. And it supports their personal development. It achieves this by providing them with a structured training programme and regular appraisals. The team members are encouraged to give feedback to improve the pharmacy's services. They feel comfortable to raise professional concerns with senior management. And the concerns are listened to and acted upon.

Inspector's evidence

The responsible pharmacist at the time of the inspection was the resident pharmacist. She was supported by a full-time NVQ level two qualified pharmacy assistant, who was also the pharmacy's manager, three part-time NVQ level two qualified pharmacy assistants and a part-time trainee pharmacy assistant. The pharmacy also employed a part-time accuracy checking technician and a part-time delivery driver. The pharmacy had been inspected six months ago and the team members were struggling to complete their workload effectively and in a timely manner. Since the previous inspection the pharmacy was operating much more efficiently and effectively. The resident pharmacist and the pharmacy manager had been employed at the pharmacy for a few months. For the first two months of their employment, the pharmacy was provided with additional team members to support the transition. Some team members had been giving extra offsite training to help them understand a new dispensing software system. On the day of the inspection the team members were ahead of their workload. They had dispensed every prescription that was due for people to collect in the next few days. And they were working a week ahead of schedule for the dispensing of the multi-compartment compliance packs. The prescription wait time for people in the pharmacy was observed to be around 5-10 minutes. The pharmacy's accuracy checking technician had been absent for the duration of the week. The pharmacy manager explained he could ask for a relief accuracy checking technician to cover the absence. But he had not felt the need to do so. The pharmacy had applied to reduce the opening hours by four hours on Saturdays. The application had been approved. The pharmacy manager explained that the dispenser's hours would be reallocated midweek to give the team additional support.

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 other 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. They completed the modules in the consultation room. So, they could do so without any distractions. The team members received a performance appraisal every six months. The appraisals were in the form of a one-to-one conversation between the team member and the pharmacy manager. The team members were asked to assess their own performance and were given the opportunity to discuss any personal goals they wanted to achieve. A team member explained she wanted practical training on some processes, rather than just theoretical training. For example, to help her complete the prescription submission process. To help her achieve her goal, the team member received one-to-one training with a colleague who was more experienced in the process.

The team members felt comfortable to raise professional concerns with pharmacist, the pharmacy manager or the pharmacy's regional development manager. The pharmacy had a whistleblowing policy. So, the team members could raise concerns anonymously. They were encouraged to give feedback to improve the pharmacy's services. And they could do this during the team's weekly meeting. Several team members had given feedback to the pharmacy manager that they were not receiving enough training to complete certain tasks. The pharmacy manager provided the team members with extra protected training time to help them achieve their goals. The pharmacy manager explained he had asked the pharmacy's regional development for extra support to help the team reorganise the dispensary shelves. The request was granted. 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 well maintained. The exterior and the retail area portrayed a highly professional image. The downstairs dispensary was small, but the benches were well organised. The floor of the dispensary was kept clear. There was a rear exit door which was kept locked during the inspection. The dispensary was generally untidy when the pharmacy was inspected six months ago. The pharmacy had made significant improvements since then. There was a clean, well-maintained sink in the dispensary for medicines preparation and staff use. There was a toilet which had a sink with hot and cold running water and other facilities for hand washing. The pharmacy had a sound-proofed consultation room with seats where people could sit down with the team member to have a private conversation. 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's services are easily accessible to people. The pharmacy manages its services appropriately and delivers them safely. It provides some medicines in multi-compartment compliance packs to help people take them correctly. And it manages the risks associated with this service. The pharmacy's team members identify people taking high-risk medicines. And they support these people to take their medicines safely. The pharmacy sources its medicines from licenced suppliers. And it manages and stores its medicines appropriately.

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. There was a doorbell next to the front entrance door for people to use to attract the attention of the team. But it was not working during the inspection. 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. 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 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. 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 the 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 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. 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 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. But team members couldn't evidence how they obtained people's consent to dispense their medicines offsite. The importance of consent was discussed. 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 assembled

using automation. It took around 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. Each day the pharmacist opened one 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 supplied medicines in multi-compartment 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 master sheet outlined which medicines were to be dispensed in packs. And at which dosage times. For example, lunch time. 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 on a first-floor room. This was to make sure they weren't distracted while dispensing. They supplied backing sheets with the packs, which listed the medicines in the packs and the directions. During the previous inspection, the team members explained they were unsure of how to add visual descriptions of the medicines in the packs onto the backing sheets. The team members had since received extra training to help them do this. But on one backing sheet, three tablets were described as 'white round tablets'. So, the information may not have always been particularly useful to people.

The pharmacy dispensed high-risk medicines for people such as warfarin. 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. The pharmacist did some basic checks with people when they came to collect their medicines. These included ensuring the person had had a recent blood test and checked their current and target INR if they were prescribed warfarin. The team members were aware of the pregnancy prevention programme for people who were prescribed valproate and of the risks. There was an information document about the programme available in the dispensary for the team members to read. 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. Two people had been identified. And they were enrolled on a pregnancy prevention programme. 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

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. And the team was up to date with the process. No out-of-date medicines were found following a check of some 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 ranges every day. And a sample checked were within the correct ranges. The CD cabinets were 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 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 members used tweezers and rollers to help dispense multi-compartment compliance packs. 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.