General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Well, Kents Bank Road, GRANGE-OVER-SANDS, Cumbria, LA11 7EY

Pharmacy reference: 1030199

Type of pharmacy: Community

Date of inspection: 09/03/2023

Pharmacy context

This community pharmacy is located on a parade of shops in the tourist village of Grange-over-Sands, Cumbria. Its main services include dispensing NHS and private prescriptions and selling over-the-counter medicines. It provides some people with their medicines in multi-compartment compliance packs. And it delivers some medicines to people's homes.

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	N/A	N/A	N/A
2. Staff	Standards met	N/A	N/A	N/A
3. Premises	Standards met	N/A	N/A	N/A
4. Services, including medicines management	Standards met	N/A	N/A	N/A
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance ✔ Standards met

Summary findings

The pharmacy appropriately identifies and manages most of the risks associated with the services it provides. It has written procedures to help the team carry out specific tasks. And it completes the records it needs to by law. Team members know how to protect the welfare of vulnerable people. But they don't always keep records of mistakes made during the dispensing process. And so, the team may miss opportunities to learn from these mistakes and make the pharmacy safer.

Inspector's evidence

The pharmacy had a set of up-to-date standard operating procedures (SOPs). The SOPs provided the team with information to help them complete various tasks. They were held electronically, and each team member had password protected access to them. Team members were required to read the SOPs that were relevant to their role and complete a short quiz to assess their understanding of them. They were required to do this within the first few months of starting employment at the pharmacy. Team members showed a clear understanding of their roles and were observed working within the scope of their role.

The pharmacy had a process to record any mistakes made during the dispensing process which were identified before the medicine was supplied to a person. These mistakes were known as near misses. Team members had access to an electronic system known as Datix, to keep these records. Within the system they were able to record when the near miss had happened and the type of near miss. For example, if they wrong number of tablets or capsules were dispensed. But the team didn’t use the system to record every near miss. And so, the team may have missed the opportunity to identity any trends or patterns. Team members were informed if they had made a near miss error, and they corrected the mistake immediately. The team demonstrated some learning from the near misses to prevent similar mistakes happening again. For example, the team had affixed warning stickers on shelves where medicines with similar names were stored. For example, amlodipine and amitriptyline. The warnings were designed to remind the team that these medicines were more likely to be dispensed incorrectly, and to take additional care. However, recently the team had removed these warning stickers during a reorganisation of the shelves. The team did feel that the reorganisation of the shelves had reduced the number of near misses made and therefore improved patient safety. The pharmacy used Datix to record and report any dispensing incidents that had reached a person. But no examples were available for inspection. The pharmacy had a concerns and complaints procedure which was displayed on a notice located in the retail area. The notice displayed the details of the pharmacy’s superintendent pharmacist’s (SI) office. The team aimed to resolve any complaints or concerns informally. If the team member could not resolve the complaint, it was escalated to the SI.

The pharmacy had up-to-date professional indemnity insurance. It was displaying the incorrect responsible pharmacist (RP) notice. This was rectified when brought to the attention of the RP. The RP register had been completed correctly. The pharmacy kept appropriate records of supplies against private prescriptions. The pharmacy retained complete controlled drug (CD) registers. And the team kept them in line with legal requirements. The team were required to complete regular balance checks of the CDs. The balance of a randomly selected CD was checked and was found to be correct. The pharmacy kept records of CDs returned to the pharmacy for destruction.

The team held records containing personal identifiable information in areas of the pharmacy that only team members could access. The pharmacy displayed a privacy notice and how it managed people's confidential data. The team placed confidential waste into a separate bag to avoid a mix up with general waste. The waste was periodically destroyed via a third-party contractor. Team members understood the importance of securing people's private information and they had all completed training about the General Data Protection Regulation (GDPR). The pharmacy had a formal written procedure to help the team raise concerns about safeguarding of vulnerable adults and children. And team members had completed some basic training on the subject. The RP and another team member had completed training via the Centre for Pharmacy Postgraduate Education. Team members described hypothetical safeguarding situations that they would feel the need to report. They had access to the contact details of the local safeguarding teams.

Principle 2 - Staffing ✔ Standards met

Summary findings

Team members do the right training for their roles, and they do ongoing training to help them keep their knowledge and skills up to date. The pharmacy has enough team members to provide its services safely. Team members can give feedback about ways the pharmacy can improve.

Inspector's evidence

The RP on the day of the inspection was a locum pharmacist and was supported by two qualified pharmacy technicians. One technician was a locum, and the other was a part of the pharmacy's relief support team. The locum technician had worked part-time at the pharmacy since January 2023. The relief technician worked at the pharmacy on an ad-hoc basis. The pharmacy also employed a part-time qualified pharmacy assistant, a part-time trainee pharmacy assistant and a part-time delivery driver. These team members were not present during the inspection. The pharmacy had not had a resident pharmacist for approximately 12 months but was expecting the position to be filled within the next few weeks. The pharmacy has been running with locum pharmacists within that time. The pharmacy had aimed to book the same locum pharmacists as much as possible to help with business continuity. The RP had worked at the pharmacy at least once a week since January 2023. Team members were managing the pharmacy's dispensing workload well and they were a few days ahead of the workload. This helped them work without time pressures. The team explained they had been working in this way since the locum technician had joined the team.

The pharmacy provided each team member with access to a third-party training programme to help support them update their knowledge and skills. The programme consisted of a range of online healthcare-related modules for team members to work through. Most modules had a short assessment for team members to complete to assess their understanding. Team members who were enrolled on a training course were given additional time to work through their respective courses. The locum technician had recently been provided with 'best in class' modules to work through. These modules were to be used alongside the pharmacy's SOPs and outlined how various processes should be carried out. For example, prescription administration. Some of the modules had short video clips demonstrating the various processes being undertaken.

Team members attended informal team meetings where they could discuss any professional concerns and give feedback on ways the pharmacy could improve. Recently the team had decided to reorganise medicines stored in the dispensary. These medicines were now stored tidily, and team members described how this measure had reduced the time they took to complete the dispensing workload. Team member were set some targets to achieve. They did their best to achieve the targets but focused on aiming to provide an efficient service for the local community.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy's premises are suitable for the services it provides, and it maintains them appropriately. Team members keep the premises clean and secure from unauthorised access. And people can have a conversation with a team member in a private area.

Inspector's evidence

The pharmacy was clean, well maintained and highly professional in appearance. Throughout the inspection, the team kept benches in the dispensary well organised with baskets containing prescriptions and medicines awaiting a final check by the RP. The dispensary was spacious, and the floor space was kept clear from obstruction. There were clearly defined areas used for the dispensing process and there was a separate bench used by the RP to complete the final checking process. The pharmacy had ample space to store its medicines. There was a private, soundproofed, and signposted consultation room available for people to have private conversations with team members.

The pharmacy had separate sinks available for hand washing and for the preparation of medicines. There was a toilet, with a sink which provided hot and cold running water and other facilities for hand washing. Team members controlled unauthorised access to restricted areas of the pharmacy. Throughout the inspection, the temperature was comfortable. Lighting was bright throughout the premises.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy generally manages its services well and provides them safely. Its services are accessible to people with a range of needs. It gets its medicines from reputable sources and stores them appropriately. Team members take the right action in response to safety alerts to help ensure that people get medicines and medical devices that are safe to use.

Inspector's evidence

People had level access into the pharmacy through the automatic main entrance door from street level. This made it easy for people using wheelchairs or pushchairs to enter the pharmacy. There was a public car park opposite the premises. The pharmacy advertised its services and opening hours in the main window. The pharmacy had a facility to provide large print-labels to people with a visual impairment. The team described how they occasionally had to help foreign visitors access healthcare. There were aware of contact details of the nearest walk-in centre where they could signpost people to. There were some healthcare related information leaflets for people to take away with them.

Team members demonstrated a general awareness of the Pregnancy Prevention Programme (PPP) for people in the at-risk group who were prescribed valproate, and of the associated risks. They described the advice they would give in a hypothetical situation, and that they would highlight any prescriptions for valproate for the attention of the RP. Team members used various stickers to attach to bags containing people's dispensed medicines. They used these as an alert before they handed out medicines to people. For example, to remind team members to ask people if they wished to book in for a flu vaccination, or the presence of a fridge line or a CD that needed handing out at the same time. Team members signed the dispensing labels to keep an audit trail of which team member had dispensed and completed a final check of the medicines. They used dispensing baskets to hold prescriptions and medicines together which reduced the risk of them being mixed up. The pharmacy had owing slips to give to people when the pharmacy could not supply the full quantity prescribed. The pharmacy offered a delivery service and kept records of completed deliveries. And it kept an audit trail of the service.

The pharmacy sent several prescriptions to be dispensed at the Well offsite hub pharmacy. This was to help reduce the dispensing workload pressure on the team. The team inputted data from the prescriptions onto an electronic system. The pharmacist then accuracy checked the data and completed a clinical check of the prescriptions before submitting the data electronically to the hub pharmacy. Prescriptions were usually dispensed at the hub pharmacy and then delivered to the pharmacy in around three days. The team had the ability to 'recall' prescriptions from the hub pharmacy. Team members did this if people needed their prescriptions dispensing immediately at the pharmacy. Dispensed medicines arrived in sealed, barcoded bags. Team members scanned the barcodes to confirm the pharmacy had received the medicines.

The pharmacy dispensed medicines for some people into multi-compartment compliance packs. These packs were designed to help people to remember to take their medicines at the correct times of the day. The medicines were dispensed into small, sealed pods relating to the day and time of the day they should be taken by the person. For example, Tuesday, morning. The dispensing workload for the packs was spread evenly over a four-week period to help the team efficiently manage the workload. The team

ordered prescriptions for people supplied with the packs a week in advance of them being due for collection or delivery. This gave the team plenty of time to manage any queries, such as medicines that were missed off prescriptions. Team members used master sheets to cross-reference prescriptions to ensure they were accurate. The packs were supplied with patient information leaflets and annotated with descriptions of the medicines inside. For example, green, round, tablet. The team kept records of any notifications of changes to treatment provided by prescribers. For example, if a person's dose had increased, or a treatment was to be stopped. They made another record of the change on the back of the master sheets and on the person's electronic medical record.

The pharmacy stored some pharmacy-only (P) medicines directly behind the pharmacy counter and some in clear, plastic containers located around the retail area. There was a notice displayed on the front of each box asking people to seek assistance if they wished to purchase any of the medicines inside. The pharmacy had a process for the team to check the expiry date of the pharmacy's medicines. Team members explained they were up to date with the process, but they were not able to show that the process was recorded. No out-of-date medicines were found by the inspector following a check of approximately 30 randomly selected medicines. The pharmacy's medicines were tidily stored in the dispensary. The pharmacy had two medical grade fridges to store medicines that required cold storage. And the team kept daily records of the fridges minimum and maximum temperature ranges. A sample of the records was seen which showed the fridges were operating within the correct ranges. The team marked liquid medicines with details of their opening dates to ensure they remained safe and fit to supply. The pharmacy had medicine waste bags and bins, sharps bins and CD denaturing kits available to support the safe disposal of medicine waste. It received medicine alerts electronically through email and the company intranet. The team actioned the alert and kept a record of the action taken.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the appropriately maintained equipment that it needs to provide its services. And it uses its equipment appropriately to help protect people's confidentiality.

Inspector's evidence

Team members had access to up-to-date reference sources. The pharmacy used a range of CE marked measuring cylinders. The pharmacy used an electronic blood pressure monitor which was due to be replaced every two years.

The pharmacy stored dispensed medicines in a way that prevented members of the public seeing people's confidential information. It suitably positioned computer screens to ensure people couldn't see any confidential information. The computers were password protected to prevent any unauthorised access. The pharmacy had cordless phones, so that 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.