General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Well, The Health Centre, Bridge Lane, PENRITH, Cumbria, CA11 8HW

Pharmacy reference: 1030226

Type of pharmacy: Community

Date of inspection: 23/01/2020

Pharmacy context

This is a community pharmacy in a large medical centre in Penrith, Cumbria. It dispenses both NHS and private prescriptions. The pharmacy team offers advice to people about minor illnesses and long-term conditions. It provides NHS services, such as the New Medicines Service and medicines use reviews. The pharmacy supplies medicines in multi-compartment compliance packs to some people living in their own 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	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 identifies the risks associated with the services it provides to people. And it has a set of written procedures for the team members to follow to help them 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 pharmacy has a process for the team members to record and analyse the mistakes that they make when dispensing. But they don't follow the process regularly. So, they may miss out on the opportunity to make specific changes to their way of working to reduce the risk of similar mistakes happening again.

Inspector's evidence

The pharmacy had a set of standard operating procedures (SOPs). And these were held electronically. They included ones for responsible pharmacist regulations and dispensing. The Superintendent pharmacist's team 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 team members described how they would ask if there was a task they were unsure about. Or felt unable to deal with. The superintendent pharmacist's team sent new and updated SOPs to the team via the eExpert training programme. The team members completed a short quiz once they had read the SOP. They needed to pass the quiz to be signed off as having read and understood the contents of the SOP.

There was a process in place to highlight near miss errors made by the team when dispensing. The team members recorded the date, time and type of the error. And the reason why the error might have happened. They were also required to enter each record onto an electronic reporting system called Datix. But the team members explained they did not always have the time to fully complete the process. The team members occasionally analysed the near miss errors to look for any trends or patterns. And the findings were discussed with the team members who were working. Those team members who were not working were informed when they next attended for work. One of the most common near miss errors involved the team picking the wrong strength of citalopram. To reduce the risk of them making the same error again, they decided to separate the different strengths away from each other. The pharmacy used the Datix system to record the details of any dispensing incidents which had reached the patient. The team was unable to access any records of any incidents or provide any examples. And so, the process was not inspected in detail.

The pharmacy displayed the correct responsible pharmacist notice. 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 accuracy checking technician (ACT) was seen completing accuracy checks on prescriptions that had been clinically checked by the pharmacist. The team members used a stamp split into four sections to record which team member had accuracy checked the prescription, clinically checked the prescription, dispensed the medicines and handed out the medicines. This ensured the pharmacy kept a robust audit trail of dispensing activities.

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 prescription and emergency supplies. The pharmacy kept CD registers. And they were completed correctly. The team had recently started checking the running balances against physical stock each week. A physical balance check of a randomly selected CD matched the balance in the register. 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 team was aware of the need to keep people's personal information confidential. And team members were seen offering the use of the consultation room to people or moving to a quieter area of the retail area, when discussing their health. They had all undertaken General Data Protection Regulation (GDPR) training. 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 destroyed via a third-party contractor.

The pharmacist and ACT had completed training on safeguarding via the Centre for Pharmacy Postgraduate Education (CPPE). And when asked about safeguarding, the team members gave several examples of the symptoms that would raise their concerns in both children and vulnerable adults. The pharmacy assistant explained how she would discuss her concerns with the pharmacist on duty, at the earliest opportunity. The pharmacy had some basic written guidance on how to manage or report a concern and the contact details of the local support teams.

Principle 2 - Staffing ✔ Standards met

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. The pharmacy team members complete training to keep their knowledge and skills up to date. They can make suggestions to improve the pharmacy's services. And they feel comfortable to raise professional concerns when necessary.

Inspector's evidence

At the time of the inspection, the responsible pharmacist was the resident pharmacy manager. She was supported by a full-time accuracy checking technician (ACT), a locum pharmacist, a locum pharmacy technician, a full-time pharmacy technician, two full-time pharmacy assistants and a part-time pharmacy assistant. The pharmacy also employed two other part-time pharmacy assistants and a delivery driver who were not present during the inspection. The resident pharmacist had only been working at the pharmacy for a few months. Before she started employment, the pharmacy was using a pool of locum pharmacists. The team members explained they found this a challenging time and the pharmacy did not always have enough team members to cope with the workload. Another Well pharmacy in the local area had recently closed, and three pharmacy assistants had moved to the pharmacy from the closed branch. Several team members who had been working at the pharmacy for several years stated the pharmacy was more appropriately staffed and managed since the arrival of the resident pharmacist and the additional dispensers. And the waiting time for prescriptions to be dispensed had reduced significantly.

The team members were observed managing the workload well and had a manageable workflow. The team members were seen asking the pharmacist for support, especially when presented with a query for the purchase of an over-the-counter medicine. They acknowledged people as soon as they arrived at the pharmacy counter. They were informing people of the waiting time for prescriptions to be dispensed and taking time to speak with them if they had any queries. The team members often worked additional hours to cover absences and holidays. The pharmacy provided the team with support if the ACT was absent. The team members did not take holidays in the run up to Christmas to make sure the pharmacy had enough team members working, as this was the busiest time of the year for the pharmacy.

The team members were able to access the online training system, eExpert, to help them keep their knowledge and skills up to date. They received training modules to complete every month. Many of the modules were mandatory to complete. The team members were also able to voluntarily choose a module if they felt the need to learn about a specific healthcare related topic, or needed help carrying out a certain process. The team members did not receive set time during the day to allow them to complete the modules. A team member said she completed some training when the pharmacy was quiet, but this was rare and so she completed the modules in her own time, without any distractions.

The team attended ad-hoc, informal meetings and discussed topics such as company news, targets and patient safety, when the pharmacy was quiet. If a team member was not present during the discussions, they were updated the next time they attended for work. The team members felt comfortable to give feedback or raise concerns with the regular pharmacist or the pharmacy's regional

development manager, to help improve the pharmacy's services. The pharmacy had a whistleblowing policy. The team was set various targets to achieve. The targets had been reduced while the newer team members settled into their roles.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is secure, hygienic and well maintained. It has a sound-proofed room where people can have private conversations with the pharmacy's team members. The pharmacy premises are small, and the team struggles to keep the dispensing and prescription storage area tidy. This may increase the risk of the team making mistakes.

Inspector's evidence

The pharmacy was professional in appearance. But it was difficult to locate from the grounds of the medical centre. The pharmacy did not have a retail area but did sell some Pharmacy medicines. The premises consisted of a waiting room, consultation room and the dispensary. The dispensary was small for the services provided. The benches were kept untidy and the area where the team stored dispensed medicines ready for collection was overflowing. Many bags and boxes were kept on the dispensary floor. Which created a risk of a trip or a fall. The pharmacy was due to undergo a full refit of the premises the week after the inspection. The team members said they were looking forward to the refit and were hoping for a better organised dispensary.

There was a clean, well-maintained sink in the dispensary for medicines preparation and staff use. The team members had access to a toilet which had a sink with hot and cold running water and other facilities for hand washing.

There was a good-sized, soundproofed consultation room at the side of the waiting area. The room was smart and professional in appearance and was signposted by a sign on the door. The room was kept locked when not in use and the team did not leave people in the room unattended. 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 suitably manages the risks associated with this service. The 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 mostly manages and stores its medicines appropriately. But the team doesn't always check the expiry date of its medicines as it should.

Inspector's evidence

The pharmacy had level access via a ramp from the grounds of the medical centre to the main entrance door. And so, people with prams and wheelchairs could enter the pharmacy unaided. The pharmacy advertised its services and opening hours in the waiting area and on the pharmacy's website. And there were several healthcare related leaflets available for people to select and take away with them.

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. This helped the team stop people's prescriptions from getting mixed up. The team had a robust process to highlight the expiry date of CD prescriptions awaiting collection in the retrieval area. 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. 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 supplied medicines in multi-compartment compliance packs for people living in their own homes. And the pharmacy supplied the packs to people on either a weekly or monthly basis. The pharmacy managed the workload across four weeks. The team was responsible for ordering people's prescriptions. And this was done in the third week of the cycle. Which gave the team members a week to resolve any queries, such as missing items or changes in doses, and to dispense the medication. They dispensed the packs in a segregated part of the dispensary. This was to minimise distractions. And they kept all documents related to each person on the service in separate wallets. The team members used progress charts. The charts helped the team visually assess the progress of the dispensing. The documents included master sheets which detailed the person's current medication and time of administration. The team members used these to check off prescriptions and confirm they were accurate. They labelled the packs, which listed the medicines in the packs and the directions. And information to help people visually identify the medicines. For example, the colour or shape of the tablet or capsule.

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. 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. One person had been identified. A team member gave the person some additional information about the programme. And explained the importance of pregnancy prevention while taking valproate.

Pharmacy medicines (P) were stored behind the pharmacy counter. So, the pharmacist could supervise sales appropriately. The medicines in the dispensary were generally stored tidily. But some drawers were cluttered. Every three months, the team members checked the expiry dates of its medicines to make sure none had expired. But the process had not been completed fully during the last check. Four out-of-date medicines were found after a random check of thirty medicines. The importance of following the date checking process was discussed with the team members. They 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 cabinets 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. And there were separate cylinders used to dispense methadone. 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.