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: 18/10/2022

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 an NHS and private 'flu vaccination service. 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

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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. 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, analyse and learn from the mistakes that they make when dispensing.

Inspector's evidence

The pharmacy had a set of standard operating procedures (SOPs) which were held electronically. They included SOPs for the responsible pharmacist (RP) regulations and dispensing. The superintendent pharmacist's (SI) team reviewed each SOP every two years on a monthly rolling cycle. This ensured that they were kept up to date. The SI team sent new and updated SOPs to the team via the company's 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. A trainee dispenser who had recently joined the pharmacy team was in the process of reading the SOPs that were relevant to their role.

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 made entries onto an electronic reporting system called Datix. The RP analysed the near miss errors to look for any trends or patterns. The RP understood the importance of completing the analysis but didn’t always have time to complete it during the pharmacy’s opening hours. This meant the RP usually completed the process when the pharmacy was closed. The findings were discussed with the team members who were working. Any team members who were not present were informed when they next attended for work. One of the most common near miss errors involved the team picking the wrong form of a medicine. For example, selecting tablets instead of capsules. The pharmacy used the Datix system to record the details of any dispensing incidents which had reached the patient. The team was unable to easily access any records of any incidents, so, the process was not inspected in detail. The pharmacy had a concerns and complaints procedure. Any complaints or concerns were verbally raised with a team member. If the team member could not resolve the complaint, it was escalated to the pharmacy’s SI team. The pharmacy displayed a poster in the retail area which encouraged people who used the pharmacy to scan a QR code which directed them to complete an online customer satisfaction survey.

The pharmacy displayed the correct RP 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 an RP. For example, they explained how they could only hand out dispensed medicines or sell any pharmacy medicines under the supervision of a pharmacist. The accuracy checking technician (ACT) was seen completing accuracy checks on prescriptions that had been clinically checked by the RP. The ACT signed the bottom corner of prescriptions to confirm she had completed an accuracy check. This ensured the pharmacy kept a robust audit trail of dispensing activities.

The pharmacy had up-to-date professional indemnity insurance. Entries in the RP record complied with

legal requirements. The pharmacy kept complete records of private prescriptions. The pharmacy kept CD registers which were correctly completed. Team members didn't always have the time while they worked to regularly check the running balances against physical stock in line with company guidance. The RP often completed the checks outside of the pharmacy's opening hours. 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. Team members offered the use of the consultation room to people 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. The pharmacy stored confidential waste in separate bin to avoid a mix up with general waste. A third-party contractor periodically collected and destroyed the waste.

The RP 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. A team member explained how they would discuss their concerns with the RP at the earliest opportunity.

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. And they support each other while they work. Team members complete some training to ensure they keep their pharmacy knowledge and skills up to date. Team members are working under some pressure, and they don't always have time to complete routine tasks or manage the dispensing workload when the pharmacy is open. This means they sometimes work outside of their normal hours to ensure the pharmacy's workload is completed.

Inspector's evidence

At the time of the inspection the RP was the pharmacy's resident pharmacist manager. The RP was supported by an ACT, a full-time pharmacy technician, two full-time trainee pharmacy assistants, and another part-time pharmacy technician. The pharmacy didn't employ any other team members except a part-time delivery driver. The ACT was a part of the company's 'relief' team and was working at the pharmacy on the day of the inspection to help the team manage a backlog with the dispensing workload. During the inspection, team members were observed managing the workload well and supporting each other. They asked 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.

The pharmacy had experienced some difficulty in retaining team members and recruiting replacements when team members left the business. It was currently recruiting for two pharmacy assistants. Although the pharmacy was fully staffed during the inspection, it had experienced several days where the team had struggled to manage the dispensing workload. Team members described how some people wanting to speak to a team member had often had to wait over 20 minutes to be seen to. People were often displeased, and team members had found it difficult to manage the queues. On two days in the past month, the RP was working with a single dispenser, they had taken the decision to close the pharmacy to the public for two hours to allow the team to catch up on the dispensing workload. Team members regularly worked more hours than they were contracted to do to help the team complete tasks that they didn't always have time to do during opening hours. For example, date checking the pharmacy's medicinal stock.

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 their working hours to allow them to complete the modules. Several team members worked through the modules on their lunch breaks or at home.

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

had a whistleblowing policy to help team members anonymously raise concerns.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean and kept secure. People using the pharmacy can speak with a member of the pharmacy team in confidence in a private consultation room.

Inspector's evidence

The pharmacy was professional in appearance. It was kept clean and hygienic. The premises consisted of a waiting area, consultation room and the dispensary. The dispensary had undergone a recent refurbishment. Team members explained the refurbishment had improved the working environment which helped them manage the dispensing workload more effectively. The benches in the dispensary were kept generally tidy throughout the inspection and floor spaces were kept clear.

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. A sign on the door promoted its use. 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 easy for people to access. The pharmacy appropriately manages its services. 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 pharmacy sources its medicines from licenced suppliers. And it safely manages and stores its medicines.

Inspector's evidence

The pharmacy had level access via a ramp from 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 in the waiting room for people to select and take away with them.

The pharmacy had recently started providing the 'flu vaccination service. Team members described how they identified people who qualified for a free NHS vaccination. They explained to people the importance of getting a vaccination as soon as possible. During the inspection, the RP administered vaccinations to several people. The pharmacy had experienced some IT issues which had prevented the team from informing people's GPs that they had been vaccinated by the pharmacy. But these issues had since been resolved and the pharmacy had a robust system in place to inform GPs that one of their patients had been successfully vaccinated.

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, 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 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 delegated some of its dispensing workload to the company's central dispensing hub pharmacy. There were some exceptions. For example, prescriptions for medicines that required cold storage, CDs and more urgent prescriptions such as for a short course of antibiotics. The team demonstrated the process of inputting details from prescriptions onto an electronic system which were then sent to the hub pharmacy. The RP completed clinical checks of the prescriptions and an audit trail of the process was in place. If required, team members were able to recall a prescription from the hub pharmacy and dispense it at the pharmacy. For example, if a person needed their medicines urgently and could not wait for the medicines to be received from the hub pharmacy.

The pharmacy supplied medicines in multi-compartment compliance packs for people living in their

own homes. It 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. This 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 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 included information to help people visually identify the medicines. For example, the colour or shape of the tablet or capsule. The pharmacy provided patient information leaflets (PIL) to people when they were dispensed a medicine in their packs for the first time. The inspector discussed the requirement of the pharmacy to provide a PIL each time a medicine was dispensed.

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. One person had been identified. The RP had given the person some additional information about the programme, and explained the importance of pregnancy prevention while taking valproate.

The pharmacy stored Pharmacy (P) medicines behind the pharmacy counter. So, the pharmacist could supervise sales. 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. Team members generally completed the process when the pharmacy was closed. The team was up to date with the process and no out-of-date medicines were found after a random check of twenty medicines. 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 pharmacy received drug alerts via email and actioned them. 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 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. It had anaphylaxis kits to support the team in providing the 'flu vaccination service.

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.