Registered pharmacy inspection report

Pharmacy Name: Well, 14 King Street, WIGTON, Cumbria, CA7 9DT

Pharmacy reference: 1030249

Type of pharmacy: Community

Date of inspection: 20/02/2020

Pharmacy context

This is a community pharmacy on a parade of shops in the town of Wigton, Cumbria. 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	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 has an up-to-date set of procedures to help 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 good-sized retail area. The dispensary was located behind the pharmacy counter. The pharmacy counter acted as a barrier between the retail area and the dispensary to prevent any unauthorised access. The dispensary was set back far enough from the pharmacy counter to allow the team members to discuss confidential matters without being overheard by people in the retail area. The pharmacist used the bench closest to the retail area to complete final checks on prescriptions. And so, he could listen in to conversations the pharmacy's team members were having with people.

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. If the team members did not have time to do this straight away, they wrote down the details onto a piece of paper. They then transferred the details onto the Datix system at the end of the working day. 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. Each team member signed the report once they had read and understood its contents. And the report was left on a table in the staff area so the team members could refer to it at any time. The most common errors involved 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. For example, co-codamol capsules and tablets, and gabapentin and pregabalin. 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 had also read a document provided by Well about the potential for errors between methadone and methylphenidate. Although errors between these medicines were not common for the pharmacy, the team members discussed how they could ensure they reduced the risk of them happening. For example, they made sure the two medicines were not kept close to 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 not dispensing a medicine in the correct slot in a multi-compartment compliance pack. The team members completed a root cause analysis and discussed ways they could stop a similar error happening again. It was established that the proper checking procedure had not been followed. And the team members discussed how they should always count the number of tablets/capsules in each slot to make sure the number was correct.

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. And it was on display in the retail area for people to see. 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). 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, at the earliest opportunity. If the team members needed further guidance, they explained they would contact the pharmacy's superintendent pharmacist's office for support.

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 if necessary.

Inspector's evidence

The responsible pharmacist at the time of the inspection was a relief pharmacist who did not work regularly at the pharmacy. He was supported by the pharmacy's manager who was an NVQ level two qualified dispenser and worked part-time, and a part-time trainee pharmacy assistant. A pharmacy assistant had worked for four hours before the inspection started and had left for the day. The pharmacy also employed a full-time resident pharmacist, three part-time pharmacy assistants and a part-time delivery driver. The team members felt they had enough staff to manage the workload when there were no absences. The team members often worked additional hours to cover absences and holidays. During the first half of the inspection, only the pharmacist and the pharmacy manager were working. And they were under some pressure to manage dispensing prescriptions and speak to people who had questions about their health or wanted to purchase an over-the-counter medicine. But this improved when the trainee pharmacy assistant joined the team for the second half of the inspection. And the team was seen managing the workload well and dispensing prescriptions in a timely manner. The team members supported each other and were seen asking the pharmacist for support, especially when presented with a query for the purchase of an over-the-counter medicine. And the pharmacy's manager was seen helping the pharmacist with data entry.

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. The modules 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. So, they could do so without any distractions. But they were not always able to take the time because of the dispensing workload. 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.

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. but no examples were provided. 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 professional in its appearance. The building was easily identifiable as a pharmacy from the outside. The dispensary was kept tidy and well organised during the inspection and the team used the bench space well to organise the workflow. Floor spaces were generally kept clear to minimise the risk of trips and falls. There were some miscellaneous rooms on the first floor of the building. There were some rooms on the second floor, but the floor was out of bounds due to an unstable floor. There was a notice in the stairwell reminding people not to access the floor. There was a clean, well-maintained sink in the dispensary for medicines preparation and staff use. There was a toilet with 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. The room was smart and professional in appearance and was signposted by a sign on the door. 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. It provides a popular vaccination service. And it suitably manages the risks associated with these services. The pharmacy's team members can demonstrate how they manage their work to ensure they work efficiently and effectively. They 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 had two entrances. One was stepped access from the street at the front of the pharmacy. The other had level access from a car park at the rear of the pharmacy. If people with wheelchairs or prams presented at the front entrance, they were told they could use the rear entrance if they wished to do so. 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.

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. If a delivery could not be completed, the medicines were stored on to a clearly marked 'failed delivery' shelf.

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 such as medicine use reviews. But the pharmacy did not always obtain consent from people to allow it to dispense their medicines away from the pharmacy. The importance of this was discussed with the team. 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 team members explained the resident pharmacist had insisted that they enter any quantities in capital letters. For example, take TWO tablets TWICE a day. This helped the pharmacist reduce the risk of errors during the final check. 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 some local care homes. And the pharmacy supplied the packs to people on either a weekly or monthly basis. The workload was managed 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 for people living in their own homes in a segregated part of the dispensary. And they dispensed packs for people living in care homes in a first-floor room. 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. For example, the dates when the prescriptions were ordered, received by the pharmacy, the packs were assembled, checked and delivered. 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 supplied backing sheets with 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. 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. And there was an alert placed next to where valproate was stored. The alert was designed to remind the team members to check if the valproate they were dispensing was for a person who met the criteria. 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. The person was given advice about the risks of becoming pregnant while taking valproate.

The pharmacy provided a popular flu vaccination service. The resident pharmacist had vaccinated over 300 people in the current flu season. An up-to-date patient group direction and a declaration of competence for the pharmacist was seen. The vaccinations were provided in the consultation room. There was a poster in the room outlining how the team members could carry out basic life support if a person suffered from an anaphylactic reaction to a vaccination. Alcohol gel, wipes, a sharps bin, disposable gloves and adrenaline injections were kept in the room. The location of the adrenaline injections was written on the basic life support poster. This helped the team easily find them.

The pharmacy provided a repeat prescription ordering service. The pharmacy ordered used cards to note down each medicine a person could order on a repeat prescription from their GP. And the person was asked which medicines they wanted to order each time they were due for their repeat prescription. The team explained this helped prevent people ordering medicines people did not need. The team members kept records of the medicines that were ordered. And the records were cross-referenced with the prescriptions to make sure they were accurate. Once the medicines had been dispensed, the team members used a text messaging service to inform the patient that their medicines were ready to be collected. The team members explained the text messaging service was new and was a good way to ensure people were receiving their medicines on time, and therefore not missing any doses.

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 cabinet was 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.