General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Well, Tesco Superstore, Transit Way, Honicknowle, PLYMOUTH, Devon, PL5 3TW

Pharmacy reference: 1030872

Type of pharmacy: Community

Date of inspection: 12/08/2020

Pharmacy context

The pharmacy is in a shopping precinct in Plymouth, next to a large supermarket. It sells over-the-counter (OTC) medicines and dispenses prescriptions. The pharmacy team gives advice to people about minor illnesses and long-term conditions. The pharmacy offers services including Medicines Use Reviews (MURs), the NHS New Medicine Service (NMS) and flu vaccinations. The inspection was carried out during the COVID-19 pandemic.

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 its risks appropriately. Team members record their errors and review them to identify the cause. The pharmacy team then makes the necessary changes to stop mistakes from happening again. The pharmacy has written procedures in place to help ensure that its team members work safely. The pharmacy asks people for their views and acts appropriately on the feedback. The pharmacy has insurance to cover its services. And it keeps all of the records required by law. It keeps people's private information safe and explains how it will be used. Pharmacy team members know how to protect the safety of vulnerable people.

Inspector's evidence

The pharmacy had an up to date business continuity plan. And it had amended it to reflect the current working restrictions due to COVID-19. The pharmacy had altered its layout during the pandemic to support social distancing. It had a one-way system and two metre markers were clearly visible on the floor. The pharmacy allowed up to four people into the pharmacy at one time. The social distancing markers were extended outside the pharmacy into the shopping precinct. A security guard managed the queues of people entering the shopping precinct, which was also the site of a supermarket and other shops. The pharmacy manager had completed an individual COVID-19 risk assessment with each team member. Team members wore face masks and sanitised their hands regularly.

The pharmacy had written procedures in place to show team members the safest way to carry out its services. Each team member could view the written procedures on their personal e-Learning account and a record was kept of when they had last been read. The team members were carrying out tasks, such as dispensing and handing out prescriptions, according to the written procedures.

The pharmacy recorded details of when mistakes were made. Errors that were picked up in the pharmacy, known as near misses, were recorded on a paper log. Team members later transferred the details to an online reporting system, Datix, which allowed them to be viewed by the company head office. The pharmacy recorded any mistakes that were handed out to people, known as dispensing errors, immediately on Datix and included a more detailed analysis of the cause. The pharmacy team discussed both near misses and dispensing errors to identify any causes. The pharmacy manager reviewed all mistakes in a monthly patient safety report. The pharmacy team then discussed the review and made changes to stop the mistakes from happening again. The pharmacy team had recently reduced the amount of stock it held to better reflect the number of prescriptions it dispensed. The shelves were organised and tidy. They had placed brightly coloured stickers on shelves holding stock of medicines that were commonly confused, for instance, those that had similar names or packaging. The pharmacy team felt that these changes had reduced the number of mistakes they made.

The pharmacy sent over half of the prescriptions it received to be dispensed at an off-site dispensary, known as Central Fulfilment. A pharmacist completed a clinical check of the prescriptions before they were sent. The pharmacy then received the completed prescription within two days. The pharmacy team had completed an audit to check the accuracy of the medicines dispensed. They had found no errors in 300 prescribed items.

The pharmacy completed a yearly community pharmacy patient questionnaire (CPPQ) survey. They also

asked people using the pharmacy for their feedback. A complaints procedure was in place and was displayed in the retail area. The pharmacy had received complaints during the COVID-19 pandemic, mainly about the need to queue in a socially distant way and the time people needed to wait for their medicines. The pharmacy had taken action to reduce waiting times by sending as many prescriptions as possible to be dispensed by Central Fulfilment, which reduced their workload and improved their efficiency. Despite some complaints, the pharmacy team felt that the feedback they had received had largely been positive and they described several times when they had received appreciative comments and encouragement from people.

The pharmacy had appropriate insurance policies in place to protect people if things went wrong. The pharmacy kept a written record of who was the responsible pharmacist (RP), and therefore in charge of the pharmacy, at any given time up to date. And they displayed a sign showing the name and registration number of the RP. Controlled drug (CD) registers were maintained appropriately. The pharmacy team completed a CD balance check regularly. And a random stock check matched the balance in the register. A separate register was used to record CDs returned to the pharmacy and these were destroyed promptly. Records of private prescriptions and emergency supplies were made in a book and were in order. The pharmacy retained records of unlicensed medicines and annotated them with all legally required details.

Team members had completed training on information governance and the General Data Protection Regulation. They had signed the associated policies. The pharmacy ensured that no personal information could be seen by people coming into the pharmacy. They stored completed prescriptions on shelves with opaque doors. Computer terminal screens were turned to face away from people using the pharmacy and the terminals were password protected. Smartcards were generally used appropriately but one that was inserted into a computer belonged to member of staff who was not present during the inspection. The RP asked people to sign a consent form if he needed to access their summary care record. If written consent was not possible, verbal consent was obtained.

All staff were trained to an appropriate level on safeguarding. The RP had completed the Centre for Pharmacy Postgraduate Education (CPPE) level 2 safeguarding training, and the remaining staff completed yearly safeguarding training on their personal e-Learning account. The RP, who was a locum, was not able to find a printed copy of the local safeguarding contacts. But they were easily accessed online. A dispenser had previously referred her concerns about some repeated requests for a medicine used to make children drowsy to the pharmacist.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough staff to manage its workload. Team members receive time in work to complete training for their roles. They are confident to suggest and make changes to the way they work to improve their services. They communicate well and give each other feedback on their performance.

Inspector's evidence

The pharmacy had enough staff on the day of the inspection. In addition to the RP, who was a locum pharmacist, there was a dispenser and a trainee medicines counter assistant (MCA). The team were managing the workload comfortably. Pharmacy team members had clearly defined roles and accountabilities. They knew what was expected of them each day. They worked regular days and hours. If anyone was absent from work through holiday or sickness, the pharmacy covered the work by asking for additional support from the team of relief dispensers. Or part-time staff increased their hours.

Team members completed training packages on their individual e-Learning account. Each team member kept records of what training they had completed. The RP regularly completed learning to keep his clinical knowledge up to date. He discussed a recent webinar he had attended with the inspector. The trainee MCA was allocated time to complete her coursework during working hours. She was making good progress through her course. She was seen to provide appropriate advice when selling medicines over the counter. And she referred to the RP for additional information as needed.

Team members were set yearly development plans and had six-monthly performance reviews. They gave each other regular ad hoc feedback and were open and honest with each other. The team regularly discussed how things were going in the pharmacy. And they gave feedback to the manager, who they found to be receptive to ideas and suggestions. Each team member knew how to raise any concerns they had about the pharmacy. And they were aware of the company whistleblowing policy.

A dispenser felt well supported by the store manager and the teams from other local pharmacies in the same company. The RP had not been set any specific targets whilst working in the pharmacy. He was able to use his professional judgement to make decisions. He only provided services such as MURs that were clinically appropriate.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy provides a safe, secure and professional environment for people to receive healthcare. It has introduced measures to reduce the risk of the spread of COVID-19. The pharmacy has a soundproofed room where people can have private conversations with members of the pharmacy team. The pharmacy is adequately secured to prevent unauthorised access.

Inspector's evidence

The pharmacy was in a shopping precinct in Plymouth, next to the entrance of a supermarket. The pharmacy had been refurbished in February 2020 and improvements had been made to the layout. The retail area was well-presented. There was a one-way system in place to allow for social distancing and there was clear signage telling people which route to take. Stickers had been placed on the floor to showing a two-metre distance. The seating area had been removed and the chairs were being used to create a barrier at the healthcare counter. The pharmacy had a consultation room that was clearly advertised. It was of an adequate size and was soundproofed to allow conversations to take place in private. It was secured with a digi-lock when the pharmacy team were not using it. The pharmacy displayed health-related leaflets and posters both in the consultation room and in the waiting area.

The medicines counter led through to a small, raised dispensary. A lockable barrier was installed to stop people walking into the dispensary. The dispensary was well organised and there was plenty of bench space. Stock was stored neatly on the shelves. Whilst work had been completed to update the areas of the pharmacy visible to the public, the dispensary fixtures and fittings were dated.

Prescriptions that were waiting to be collected were stored using a retrieval system. They were placed on shelves that had been fitted with opaque doors. No confidential information was visible to people waiting. The pharmacy was light and bright. It had air-conditioning. Pharmacy team members made sure that the pharmacy was clean and tidy. Disinfectant was used to clean the counter tops. Hand sanitising gel was placed around the pharmacy for people to use.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy is accessible and advertises its services appropriately. Medicines are supplied safely. The pharmacy offers a range of additional services, which the pharmacy team delivers safely. Team members providing the services ensure that their training is up to date. The pharmacy obtains its medicines from reputable suppliers. It stores them securely and makes regular checks to ensure that they are still suitable for supply. The pharmacy delivers medicines to people safely and keeps appropriate records of this. The pharmacy accepts unwanted medicines and disposes of them appropriately.

Inspector's evidence

The pharmacy had a wide, step-free entrance. The consultation room was wheelchair accessible. Team members communicated with people with hearing impairments in the consultation room, using pen and paper if needed. A range of health-related posters and leaflets was displayed. They advertised details of services offered both in the pharmacy and locally. A dispenser described that if a patient requested a service not offered by the pharmacy at the time, she would refer them to other nearby pharmacies, calling ahead to ensure the service could be provided there. The pharmacy accessed up-to-date signposting resources and details of local support agencies online.

The pharmacy had a clear and well-organised workflow. It used dispensing baskets to store prescriptions and medicines to prevent transfer between patients. There were designated areas to dispense prescriptions and complete the accuracy check. The dispenser and the pharmacist initialled the labels of dispensed items to create an audit trail.

The pharmacy used stickers and highlighter pens to draw attention to prescriptions for fridge items and CDs in schedules 2 and 3. It also placed stickers on prescriptions containing high-risk medicines or medicines that may require additional advice from the pharmacist. When significant interventions were made, team members recorded details on the patient medication record (PMR). The pharmacy provided substance misuse services. The pharmacist observed some people taking their medicines in the consultation room. The RP liaised with the prescriber or the key worker to report erratic pick-ups and to discuss any other concerns about users of the service. The RP had a brief discussion with each person accessing the service to check on their wellbeing.

The pharmacy offered a range of additional services including flu vaccinations. Details of the service for the upcoming season had not yet been released by the NHS. The RP had completed training on injection techniques and anaphylaxis and resuscitation within the last two years. The pharmacy was a Healthy Living Pharmacy and provided additional advice to people on living healthy lifestyles. It had an eye-catching health promotion zone displaying leaflets and information on both locally and nationally relevant topics.

The pharmacy had completed the audit of people at risk of becoming pregnant whilst taking sodium valproate as part of the Pregnancy Prevention Programme (PPP). Appropriate conversations had been had with affected people and records were made on the PMR. The pharmacy had stickers for staff to apply to valproate medicines dispensed out of original containers to highlight the risks of pregnancy to women receiving prescriptions for valproate. The pharmacy had the information booklets and cards to

give to eligible women. Notes were placed on the PMR of women receiving valproate to confirm a discussion about PPP had taken place.

The dispensary shelves used to store stock were organised and tidy. The stock was mostly arranged alphabetically. Team members checked the expiry dates of all medicines regularly and kept appropriate records. Spot checks revealed no date-expired medicines or mixed batches. The pharmacy had the hardware and software to be compliant with the Falsified Medicines Directive (FMD). But the pharmacy team were not currently scanning FMD compliant packs. But they were making visual checks on FMD compliant packs of medicines. Prescriptions containing owings were appropriately managed. The prescription was kept with the balance until it was collected. Stock was obtained from reputable sources including Alliance and AAH. Invoices were seen to this effect. Records of recalls and alerts were received by email and on the intranet. When they were actioned by the pharmacy team, they were annotated with the outcome and the date. This information was sent to the pharmacy's head office.

The fridge in the dispensary was clean, tidy and well organised. There was a separate small fridge for team members to use. No medicines were stored in the small fridge. A team member checked the maximum and minimum temperature of the fridge every day and made a record of it. CDs were stored in accordance with legal requirements. Denaturing kits were available for safe destruction of CDs. Patient returned CDs were recorded in a register and destroyed with a witness with two signatures were recorded.

The pharmacy kept records of deliveries made to people in their own homes. Signatures were not currently being obtained due to social distancing requirements. The pharmacy team described the process followed in the event of failed deliveries to ensure that patients received their delivery in a timely manner, particularly those considered to be vulnerable, and this was found to be adequate.

The pharmacy dealt with medicines returned to them by people appropriately. Personal details were removed from returned medicines to protect people's confidentiality.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy uses appropriate equipment and facilities to provide its services. It ensures its equipment is well-maintained. The pharmacy uses its equipment in a way that protects people's private information.

Inspector's evidence

The pharmacy had installed Perspex screens on the medicines counter during the COVID-19 pandemic. They cleaned them regularly. The pharmacy had an adequate supply of personal protective equipment, including face masks and gloves. Team members were wearing face masks during the inspection. Hand sanitiser was readily available.

The pharmacy had a range of crown-stamped measuring cylinders to allow them to accurately measure liquids. They also had some measures that were clearly marked for the use of controlled drugs only. There was a range of clean tablet and capsule counters, with a separate tablet counter clearly marked for more high-risk medicines. The pharmacy kept all of its equipment, including the dispensary fridge and sink, in good working order.

The pharmacy had up-to-date reference sources. And team members could easily access information on the internet. They ensured they used reputable websites when looking for clinical information. Computer screens were positioned so that no information could be seen by members of the public. Phone calls were taken away from public areas. Dispensed prescriptions were stored in a retrieval system with no confidential information visible to people waiting.

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.