General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Ashby Pharmacy, 213 Ashby High Street, SCUNTHORPE, South Humberside, DN16 2JP

Pharmacy reference: 1032501

Type of pharmacy: Community

Date of inspection: 26/10/2023

Pharmacy context

This community pharmacy is on the High Street in Ashby, a suburb of Scunthorpe, North Lincolnshire. Its main services include dispensing NHS and private prescriptions and selling over-the-counter medicines. The pharmacy provides a seasonal flu and COVID vaccination service and substance misuse services. And it supplies a range of medicines to people for the treatment of minor ailments and illnesses. The pharmacy supplies some medicines in multi-compartment compliance packs, designed to help people remember to take their medicines. And it delivers some medicines to people's homes.

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 adequately identifies and manages the risks associated with its services. It keeps people's confidential information secure. And it uses feedback it receives from people to inform the way it delivers its services. Overall, the pharmacy keeps the records required by law. Its team members know how to recognise and respond to safeguarding concerns. And they engage in regular conversations to help reduce risk following mistakes made during the dispensing process.

Inspector's evidence

The pharmacy had a range of standard operating procedures (SOPs) to support its safe and effective running. The most recent version of SOPs had been implemented in May 2023. And they contained clear information about any changes made at the last review. Team members knew how to access the SOPs and those spoken to said they had read and understood them. But the pharmacy did not ask its team members to complete training records to confirm their understanding of the SOPs. Team members on duty had a good understanding of their roles and responsibilities. And they were confident in referring queries to the pharmacist. They were aware of what tasks could not be completed should the responsible pharmacist (RP) take absence from the pharmacy.

The pharmacy had processes for managing mistakes made and identified during the dispensing process, known as near misses. Pharmacy team members received verbal feedback after a near miss and they worked to correct their own mistakes. The pharmacy had an electric near miss reporting record, but the team members did not always record details of their near misses on the record. This meant there may be some missed opportunities to recognise trends in mistakes and to share learning. Team members explained that they tried to minimise interruptions during the dispensing process to help reduce risk. And if they found stock in the wrong location in the dispensary, they acted immediately to move it to the correct location. They informed other team members of this to help increase vigilance when unpacking the stock order. The pharmacy had a process for reporting mistakes identified following a person receiving a medicine. Evidence of incident reporting was seen and included learning outcomes designed to reduce risk.

The pharmacy had a complaints procedure. But it did not advertise how people could provide feedback or raise a concern. Team members had a clear understanding of how to manage feedback and they aimed for local resolution of concerns wherever possible. They explained how they used feedback to inform improvements to services. For example, they had strengthened the stock checks they made and the communication they had with prescribers to reduce the number of medicines they owed to people. The pharmacy had a safeguarding procedure and information for local safeguarding teams was accessible to its team members. The SI had completed safeguarding learning through the Centre for Pharmacy Postgraduate Education. Other team members discussed completing e-learning on the subject. And they knew how to raise, and report concerns to help keep vulnerable people safe.

The pharmacy held all personal identifiable information in the staff-only area of the premises and on password protected computers. Confidential waste was separated, and this was disposed of securely. But there was a large overage of confidential waste waiting to be disposed of. This was stored safely and held in the staff-only area. The pharmacy had current indemnity insurance. The RP notice displayed

had the correct details of the RP on duty. RPs signed into the RP record as required but they did not regularly sign-out of the record. A sample of private prescription records seen generally complied with legal requirements, some entries did not include the details of the prescriber. Records of unlicensed medicines were held with full details of who the medicine had been supplied to as required. The pharmacy maintained running balances in its electronic controlled drug (CD) register and completed balance checks of most stock against the register regularly through balance checking stock against the register upon receipt and upon supply. But full balance checks of all stock against the balance recorded in the CD register were infrequent. A random physical balance check conducted during the inspection complied with the running balance in the register. The team recorded patient-returned CDs in a separate register at the point of receipt.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough team members to manage its workload effectively. It enrols its team members on learning relevant to their role. Pharmacy team members work well together and are supportive of each other. They engage in regular conversations to help share learning. And they know how to provide feedback or raise a concern at work.

Inspector's evidence

On duty was the SI undertaking the role of RP, a qualified dispenser, two trainee dispensers and the delivery driver. The pharmacy also employed an apprentice. Team members occasionally worked flexibly to cover for leave. The SI explained the pharmacy’s workload was rising, and in response to this they were monitoring staffing levels and skill mix. Team members were up to date with their work, and they were observed prioritising acute prescriptions to make sure people received their medicines in a timely manner.

Trainees were enrolled on a GPhC accredited training course associated with their roles. A discussion highlighted the need for the delivery driver to be enrolled on a GPhC accredited learning course within three months of starting their role. The SI confirmed the apprentice received learning time as required as part of their learning role. But other trainees did not generally receive time at work to complete their learning. They were confident in asking questions and in seeking support for their learning from the SI. Team members were observed working well together. They engaged in regular group discussions to share information such as updates to services, workload management and safety. The pharmacy had a whistleblowing policy, and its team members knew how to raise a concern at work. A team member provided an example of providing feedback within a group discussion which had been upon appropriately. The pharmacy did not set targets for its team members to meet.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are clean and secure. They are appropriately maintained, and they provide facilities designed to protect people's privacy when speaking to members of the pharmacy team.

Inspector's evidence

The pharmacy was secure and maintained to an adequate standard. There was one current maintenance issue as the door to the consultation room was broken. The SI had put a curtain up as a temporary measure to help provide some privacy to people attending for services such as vaccinations. And extra care was being taken when holding discussions with people in the room to ensure their privacy was maintained. Team members reported that recent health and safety checks such as fire extinguisher checks had been carried out. The pharmacy was clean and generally organised. Some equipment such as medical waste receptacles and bags of confidential waste lined a corridor leading from the dispensary. This equipment did not pose a trip or fall hazard. Team members had access to sinks equipped with antibacterial hand wash and paper towels. Heating and ventilation arrangements were sufficient with air conditioning provided in part of the premises.

The public area was small and open plan. Access to the consultation room was available from the public area and team members were able to monitor access into the room. The room was clean and organised and was used throughout the inspection. Access into the dispensary was from behind the medicine counter. The dispensary was a good size. It consisted of two rooms; the first room was used to manage the majority of dispensing services with the back room used to manage the multi-compliance compartment pack service. Space was managed well in both rooms. Off the dispensary there was access to an office, staff facilities and a stock room.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy’s services are accessible to people. It obtains its medicines from licensed sources. And overall, it stores its medicines appropriately. Its team members carry out regular checks to ensure medicines remain safe to supply to people. They engage with people well when delivering the pharmacy’ services. And they provide relevant information to help people take their medicines safely.

Inspector's evidence

People accessed the pharmacy through an automatic door at street-level. There was a small slope leading up from the entrance, a handrail was provided to the side of the slope for people to use to support them with access. The pharmacy displayed valuable information for people to see, such as its opening times and details of its services. Pharmacy team members had good knowledge of the local area. They knew to signpost people to other pharmacies or healthcare services if they required a service or medicine the pharmacy could not provide.

Team members had access to appropriate information to support them in delivering the pharmacies services. For example, a team member was observed completing a consultation for the minor ailments service and was able to refer to the formulary and make a record of supply during the consultation process. The SI kept up-to-date information to support the safe supply of the vaccination services to hand in the consultation room. They had completed appropriate learning to support them in delivering these services. The pharmacy provided some substance misuse services, including needle exchange and supervised consumption of medicines. They demonstrated how they managed the risks associated with providing these services. For example, team members transcribing information from prescriptions to the computer system had their entries accuracy checked by a pharmacist to ensure the data had been entered accurately before dispensing could begin for each new prescription. The SI explained how safety tools built-in to the clinical software helped to manage risks during the dispensing process. For example, the system would highlight if people missed three consecutive doses which would prompt the team to contact the substance misuse service. Team members were keen to reduce harm when providing the needle exchange service by adopting an exchange-only policy which encouraged people to dispose of their used needles safely by returning them to the pharmacy.

The pharmacy protected Pharmacy (P) medicines from self-selection as it displayed them behind the medicine counter. And team members were observed referring queries to the pharmacist appropriately. The team had some processes to identify higher-risk medicines during the dispensing process. This prompted verbal counselling when medicines were handed out. But the outcome of these interventions was not recorded on the patient medication record (PMR) to support continual care. The pharmacy team was not aware of all recent legal changes about supplying valproate in original packs. A discussion of these changes led the SI to review how the pharmacy supplied valproate to ensure it supplied the medicine as the changes required. Team members had an awareness of the requirements of the valproate Pregnancy Prevention Programme. And prescriptions for valproate contained supportive information to the pharmacist of the checks carried out by prescribers.

The pharmacy used baskets throughout the dispensing process. This kept medicines with the correct prescription form, and it helped the team manage its workload. For example, it used different coloured

baskets for different workstreams, such as those requiring delivery. Pharmacy team members took ownership of the work they completed by signing their initials in the 'dispensed by' and 'checked by' boxes on medicine labels. The pharmacy kept a record of the medicines it owed to people, and team members used the original prescription when dispensing owed medicines. It kept an audit trail of the medicine deliveries it made to people's homes.

The pharmacy had an effective schedule to support it in managing work when supplying medicines in multi-compartment compliance packs. Team members used the PMR system to support it in supplying medicines in this way. The pharmacy received some prescriptions for its compliance packs weekly through repeat dispensing. It assembled and accuracy checked four weeks of compliance packs against the first prescription in the four-weekly cycle. It had robust processes to ensure each weekly pack was checked against the current prescription which was downloaded from the NHS spine each week. This included checking the assembled compliance pack contents against the prescription and the RP completing a final check of the compliance pack with the prescription. But this practice was not reflected within the pharmacy's dispensing SOPs. A sample of compliance packs found clear descriptions and dispensing audit trails on the attached backing sheets. And the pharmacy routinely provided patient information leaflets at the beginning of every four-week cycle of compliance packs. But the backing sheets did not include adverse warnings about the medicines inside the compliance packs. The team acted swiftly to rectify this issue following the inspection.

The pharmacy sourced medicines from licensed wholesalers and specials manufacturers. It generally stored medicines in an orderly manner with most stored within their original packaging. But some medicines were found in stock which were not kept in their original packaging. This was discussed with the team and the medicines were disposed of. It held its CDs in secure cabinets, and it held medicines requiring cold storage in a suitable fridge which was equipped with a thermometer. The pharmacy kept temperature records for the fridge which showed it was operating within the required range of two and eight degrees Celsius. Team members completed regular date checking tasks, and they recorded these checks. A random check of dispensary stock found one out-of-date packet of testing strips; the packet was appropriately disposed of. Team members explained they tried to mark short-dated medicines to help prompt extra checks during the dispensing process. The pharmacy had appropriate medicine waste receptacles and sharps bins available. It received medicine alerts through email and the team acted in a timely manner to check the alerts it received.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs for providing its services. It monitors it equipment to ensure it remains in safe working order. And pharmacy team members act with care by using the pharmacy's facilities and equipment safely, and in a way which protects people's confidentiality.

Inspector's evidence

The pharmacy stored bags of assembled medicines out of the direct view of the public area. Its computer monitors were suitably protected from unauthorised view. Pharmacy team members used a cordless telephone handset. This allowed them to move out of earshot of the public area when discussing confidential information over the telephone. They had access to written reference resources as well as the internet. And they used NHS smartcards and passwords when accessing people's medication records.

Pharmacy team members used a range of clean counting and measuring equipment for liquids, tablets, and capsules. It used an automated dispensing machine to support it in dispensing medicines for substance misuse services. Team members completed calibration checks of this machine daily and kept electronic records of these checks. Equipment to support the pharmacy's consultation services was readily available. This included a blood pressure machine from a recognised manufacturer and appropriate equipment to support the emergency treatment of anaphylactic reaction to support the pharmacy in providing the vaccination services safely.

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.