Registered pharmacy inspection report

Pharmacy Name: Well, 36 Pickup Street, Clayton le Moors, ACCRINGTON, Lancashire, BB5 5NS

Pharmacy reference: 1033059

Type of pharmacy: Community

Date of inspection: 13/02/2020

Pharmacy context

The pharmacy is in a residential area in Clayton Le Moors. Pharmacy team members dispense NHS prescriptions and sell a range of over-the-counter medicines. They offer services including medicines use reviews (MURs) and the NHS New Medicines Service (NMS). And, they provide seasonal flu vaccinations. The pharmacy supplies medicines to people in multi-compartment compliance packs. Some of these people live in care homes. And the pharmacy delivers medicines to people at home.

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 has procedures to identify and manage risks to its services. Pharmacy team members follow them to complete the required tasks safely and effectively. And they complete assessments to provide assurance they understand the procedures. Pharmacy team members know how to safeguard the welfare of children and vulnerable adults. They protect people's confidential information. And keep the records they must by law. Pharmacy team members record and discuss mistakes that happen. They use this information to learn and reduce the risk of further errors. But they don't always discuss or record information about why these mistakes happen. And they don't always make changes to help reduce the risks. So, they may miss opportunities to improve and make pharmacy services safer.

Inspector's evidence

The pharmacy had a set of standard operating procedures (SOPs) in place to manage the risks to its services. And they were available for pharmacy team members electronically. The superintendent pharmacist's (SI) 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 training system approximately each month. Pharmacy team members read the procedures. And some procedures required them to complete a test. If they passed the test, they could complete the sign off process as having read and understood it. If a procedure did not have an associated test, pharmacy team members ticked a box to confirm they had read and understood the procedure. The pharmacy defined the roles of the pharmacy team members in each SOP. Tasks were further defined by frequent discussions amongst pharmacy team members. The pharmacy's most popular service recently had been the flu vaccination service. It had up-to-date patient group direction (PGD) documents available. And these had been signed by the pharmacist. It also had SOPs in place for the service. The pharmacist completed physical vaccination training every two years. And theoretical training every year. The pharmacist explained he had carried out a visual risk assessment before starting the service. And this had been to make sure the right equipment was in place and the private consultation room was suitable. He did not document his risk assessment.

The pharmacist highlighted near miss errors made by pharmacy team members when dispensing. Pharmacy team members recorded their own mistakes electronically. And they discussed the errors made with the pharmacist and colleagues. They did not discuss or record much detail about why a mistake had happened. They often stated that being busy of short-staffed had caused the error. But they tried to make changes to prevent isolated incidents happening again, for example by separating look-alike and sound-alike (LASA) medicines kept next to each other on the shelves. The electronic system created reports about near miss errors, based on quantitative information, such as the number of strength or quantity errors occurring. Pharmacy team members did not discuss the electronic analysis information. And they did not analyse the data for patterns of causes. The pharmacist explained this was currently because of time pressures in the pharmacy, particularly on his time taken up by checking prescriptions and providing services to people. He said his plan was to introduce a monthly analysis of all the data collected about errors. And to have a huddle to discuss this with the team. But he hadn't been able to achieve this yet. The pharmacist explained a change the team had made after he had noticed a pattern of errors occurring while he was checking. He had noticed an increased number of errors being made between 11.00 and 12.30 each day. This was the time the delivery driver arrived to collect the day's deliveries. At the time, pharmacy team members picked and

assembled prescriptions for delivery on the same day they were due to be delivered. And they did not send any prescriptions for delivery to the company's off-site dispensing hub. They explained this put them under more pressure between 11.00 and 12.30 each day. And they believed this was the cause of the increase in mistakes. Pharmacy team members discussed the pattern of errors. And they changed their system. Now they sent as many delivery prescriptions as possible to the company's off-site dispensing hub. They also changed their process to allow prescriptions for delivery to be dispensed, assembled and checked the day before the delivery was due. This had helped to prevent a spike in workload between 11.00 and 12.30 each day. It had reduced pressure on the team. And had led to a reduction in near miss errors. The pharmacy had a clear process for dealing with dispensing errors that had been given out to people. It recorded incidents electronically. Pharmacy team members discussed each mistake that happened. But the records available gave little information about their discussions, the causes of each error or what they had changed to make the pharmacy safer. One example of a recent error involved the pharmacy providing someone with the wrong strength of atorvastatin tablets. Pharmacy team members could not give any examples of any changes they had made to reduce the risk of the error happening again. The inspector looked at where atorvastatin was kept in the drawers. The pharmacy kept different strengths of atorvastatin mixed together. And these different strengths were similarly packaged.

The pharmacy had a procedure to deal with complaints handling and reporting. It had a practice leaflet available for customers in the retail area which clearly explained the company's complaints procedure. It collected feedback from people by using questionnaires. Pharmacy team members were not aware of the feedback from the last set of questionnaires analysed. They explained they had received feedback about pharmacy waiting times before. They had managed this by acknowledging people as soon as possible when they came in to the pharmacy. And by trying to manage people's expectations about how long it would take to provide their prescriptions.

The pharmacy had up-to-date professional indemnity insurance in place. The pharmacy kept controlled drug (CD) registers complete and in order. It kept running balances in all registers. And these were audited against the physical stock quantity weekly, including methadone. It kept and maintained a register of CDs returned by people for destruction. And this was complete and up to date. The pharmacy maintained a responsible pharmacist record on paper. And it was complete and up to date. The pharmacist displayed their responsible pharmacist notice to people. Pharmacy team members monitored and recorded fridge temperatures daily. They kept private prescription records in a paper register, which was complete and in order. And, they recorded emergency supplies of medicines electronically. They recorded any unlicensed medicines supplied, which included the necessary information in the samples seen.

The pharmacy kept sensitive information and materials in restricted areas. It collected confidential waste in dedicated bags. These bags were sealed when they were full. And they were collected by a specialist contractor and destroyed securely. Pharmacy team members had been trained to protect privacy and confidentiality. They completed training via the eExpert online training system each year. And they had last trained in 2019. Pharmacy team members were clear about how important it was to protect confidentiality. And there was a procedure in place detailing requirements under the General Data Protection Regulations (GDPR). A pharmacy team member gave a clear explanation of how they would raise concerns about vulnerable children and adults. The pharmacy had a procedure in place instructing pharmacy team members where to raise their concerns and how to obtain advice. The pharmacist trained in safeguarding every two years. Other pharmacy team members had not completed any formal training.

Principle 2 - Staffing ✔ Standards met

Summary findings

Pharmacy team members are suitably qualified and have the right skills for their roles and the services they provide. Under normal circumstances, it has the right number of team members to manage the workload. But when pharmacy team members are absent, the pharmacy sometimes struggles to keep up with the workload. And to maintain the consistency of key administration and operational tasks. The pharmacy provides access to comprehensive training materials. Pharmacy team members complete training regularly to improve their knowledge and skills. They reflect on their own performance informally, discussing any training needs with the pharmacist and other team members. And they support each other to reach their learning goals. Pharmacy team members feel able to raise concerns and use their professional judgement.

Inspector's evidence

At the time of the inspection, the pharmacy team members present were a pharmacist and five dispensers. Two of the dispensers were relief staff. And one of these was the temporary pharmacy manager. The pharmacy currently had two team members who were absent long-term. One of these was an accuracy checking dispenser. Pharmacy team members said their current issue was capacity to check prescriptions in the absence of the accuracy checking dispenser. The pharmacist said he was managing to cope. But some key planning and administration tasks were not being completed, such as near-miss and dispensing error analysis. The pharmacy manager explained that during the inspection, the pharmacy had a relief dispenser. But they were not always available. And it was very difficult to manage unplanned absences.

Pharmacy team members completed training via the eExpert online training system and by regular discussions with the pharmacist and pharmacy team members. They received training modules to complete about various subjects each month. And, these included new procedures and their associated assessments. Pharmacy team members said they usually completed training at home in their own time because there was not time to complete training at work. Pharmacy team members received an appraisal with the manager every year. They discussed different aspects of their roles and performance. And set objectives to address areas identified for improvement. One example of an objective set by a dispenser was to be more confident to ask colleagues for help or to ask them if a routine task had been completed. She said she had been supported by colleagues to achieve this. And her colleagues were responding well when she asked for help.

A pharmacy team member explained she would raise professional concerns with the pharmacist, store manager or area manager. She felt comfortable raising a concern. And confident that her concerns would be considered, and changes would be made where they were needed. The pharmacy had a whistleblowing policy. And pharmacy team members knew how to access the procedure. Pharmacy team members communicated with an open working dialogue during the inspection. They discussed areas for improvement. And made changes to improve service delivery. The most recent example they gave was the change to the was delivery prescriptions were prepared. They had changed the system to help relieve pressure on the team during certain times of day. And this had helped to reduce the number of mistakes being made. The company asked the team to achieve targets in the number of MUR consultations provided to people. The pharmacist explained he had not been delivering the service long. And the team were being supported to deliver the service by the area manager.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean and properly maintained. It provides a suitable space for the health services provided. And the pharmacy has a room where people can speak to pharmacy team members privately.

Inspector's evidence

The pharmacy was clean and well maintained. Most areas of the pharmacy were tidy and well organised. And the floors and passage ways were generally free from clutter and obstruction. Some areas of bench space were cluttered with a baskets containing prescriptions waiting to be checked. But, during the inspection, the pharmacist was working hard to clear the backlog, whilst continuing to provide services, such as medicines use reviews (MUR). There was a safe and effective workflow in operation, with clearly defined dispensing and checking areas. And, there was a room on the first floor which was used to dispense multi-compartment compliance packs and medicines for two care homes. The pharmacy kept equipment and stock on shelves throughout the premises. It had a private consultation room available. Pharmacy team members used the room to have private conversations with people. The room was signposted by a sign on the door.

The pharmacy had a clean, well maintained sink in the dispensary used for medicines preparation. There was a toilet, which provided a sink with hot and cold running water and other facilities for hand washing. Heat and light in the pharmacy was maintained to acceptable levels. The overall appearance of the premises was professional, including the exterior which portrayed a professional healthcare setting. The professional areas of the premises were well defined by the layout and well signposted from the retail area.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's services are easily accessible to people. And, it provides its services safely and effectively. Pharmacy team members use new technology to improve delivery of the pharmacy's services. Pharmacy team members dispense medicines into devices to help people remember to take them correctly. And they generally manage this service well. Pharmacy team members identify people taking high-risk medicines. And they provide these people with advice to help them take these medicines safely. The pharmacy sources and stores its medicines appropriately. And it manages its medicines effectively.

Inspector's evidence

The pharmacy had level access from the pavement. It advertised its services to people using a display in the window. And on a display inside the pharmacy. Pharmacy team members helped people by using written communication with someone with a hearing impairment. And the pharmacy had a hearing induction loop. Pharmacy team members could provide large print labels and instruction sheets to help people with visual impairment.

Pharmacy team members attached labels to bags of dispensed medicines that contained a unique barcode. When they were ready to store a completed prescription bag, they scanned the barcode using a hand-held device. The information on the device was linked to the electronic patient medication records system. Pharmacy team members chose a location to store the bag. And, they scanned the barcode attached to the location and placed the bag on the shelf. When people came to collect their medicines, pharmacy team members entered their details into the hand-held device. The device then told them where the bags were stored. Pharmacy team members marked the bag as collected and a record was made of the time and date of collection. They explained that the system helped to prevent bags kept in different locations being missed and the patients leaving without all their prescription. For example, if part of their prescription was being stored in the fridge or the controlled drugs cabinet as well as on a shelf. Pharmacy team members also explained that the system helped them to identify if a patient had forgotten to collect a prescription previously.

The pharmacy sent a proportion of its prescriptions to the company's off-site dispensing hub, where medicines were picked and assembled by a dispensing robot. A dispenser explained that prescriptions were assessed to establish whether they were suitable to be sent to the hub. She said it took three days for prescriptions to be processed and medicines to be returned from the hub. So, the pharmacy continued to dispense prescriptions for urgent acute items, such as antibiotics, medicines stored in the fridge or prescriptions for unusual quantities of medicines. Prescriptions sent to the hub were most commonly for people's regular repeat medication. The dispenser also explained that part of the prescription could be sent to the hub for assembly. And, the other parts, unsuitable for the hub, could be dispensed in the pharmacy. When a prescription was received, pharmacy team members annotated on the electronic prescription token which items were being sent to the hub and which items were for the team to dispense. Then, they generated the dispensing labels. The labels for items to be dispensed in the pharmacy were printed. And the prescription data for medicines assembled at the hub was sent to the hub pharmacy electronically. Once the prescription data had been inputted, the prescriptions were held in a queue for the pharmacist to perform a clinical and accuracy check. The pharmacist logged on to the system to perform the necessary checks. Once the pharmacist was satisfied, they

released the prescription which was then sent to the hub for assembly. Only the pharmacist, using their personal smart card and password, were able to perform the clinical and accuracy check and release prescriptions to the hub. Once released, pharmacy team members dispensed and packaged any medicines that were unsuitable for the hub. And, they filed the prescriptions ready for the hub medicines to be received. Two days later, the pharmacy received the items dispensed at the hub. It received the medicines in sealed packages. Pharmacy team members married up the bags with the relevant prescriptions and any medicines that had already been prepared. And, the bags were scanned on to shelves ready for collection.

Pharmacy team members signed the dispensed by and checked by boxes on dispensing labels. This was to maintain an audit trail of staff involved in the dispensing process. They used dispensing baskets throughout the dispensing process to help prevent prescriptions being mixed up. The pharmacist provided counselling and information to people presenting prescriptions for valproate who might become pregnant. He checked with them whether they were enrolled on a pregnancy prevention programme. And contacted their GP to find out if necessary. The pharmacy had a stock of information material to give to these people who were prescribed valproate. Pharmacy team members had carried out an audit of their patients to find out who was regularly prescribed valproate. The audit had identified two people. The pharmacist had contacted both people to establish their risks. And to provide them with appropriate advice. The pharmacy supplied medicines in multi-compartment compliance packs to two care homes and to people in their own homes. One care home ordered their own prescriptions. When the pharmacy received the prescriptions, they sent them back to the home to be reconciled. Care home staff managed any prescribing anomalies they found. Then sent the prescriptions back to the pharmacy to be dispensed. Pharmacy team members collected prescription orders from the second care home and took them to the GP surgery. Pharmacy team members reconciled and managed any discrepancies found on the prescriptions received. They recorded any changes or communications about people's medicines on the patient's individual medication event diary. Pharmacy team members dispensed medicines into labelled multi-compartment compliance packs. Each pack provided a 28-day supply of medicines for the patient. Each pack was provided with an accompanying medication administration record (MAR). Each MAR provided information about how the medicines should be taken, what the medicines looked like and any accompanying warnings. Care home staff used the MAR to record when a dose had been taken or given. Pharmacy team members provided people with information leaflets about their medicines each month. For people in their own homes, pharmacy team members attached backing sheets to the packs, so people had written instructions of how to take their medicines. Pharmacy team members did not routinely include descriptions of what the medicines looked like on the backing sheets, so they could be identified in the pack. They provided people with patient information leaflets about their medicines with every pack. Pharmacy team members documented any changes to medicines provided in packs on the person's medication event diary. And on their electronic medication record. The pharmacy delivered medicines to people. It recorded the deliveries made and asked people to sign for their deliveries using the driver's electronic hand-held device. The delivery driver left a card through the letterbox if someone was not at home when they delivered. The card asked people to contact the pharmacy. The team highlighted bags containing controlled drugs (CDs) with a sticker on the bag and on the driver's electronic record.

The pharmacy stored medicines tidily on shelves. And all stock was kept in restricted areas of the premises where necessary. Pharmacy team members had completed training about the Falsified Medicines Directive. And, they were checking packs of medicines to make sure tamper evident seals were intact. The pharmacy had the necessary scanners in place to scan medicines packaging. And pharmacy team members were regularly scanning packs to decommission them from the supply chain. The pharmacy had adequate disposal facilities available for unwanted medicines, including CDs. Pharmacy team members kept the CD cabinet tidy and well organised. And, out of date and patient

returned CDs were segregated. The inspector checked the physical stock against the register running balance for three products. And they were found to be correct. The pharmacy team kept the contents of the pharmacy fridge tidy and well organised. They monitored minimum and maximum temperatures in the fridge every day. And they recorded their findings. The temperature records seen were within acceptable limits. Pharmacy team members checked medicine expiry dates every 12 weeks. And records were seen. They highlighted any short-dated items with a sticker on the pack up to three months in advance of its expiry. And they recorded expiring items on a monthly stock expiry sheet, for removal during their month of expiry. The pharmacy responded to drug alerts and recalls. And, any affected stock found was quarantined for destruction or return to the wholesaler. It recorded any action taken. And, records included details of any affected products removed.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the necessary equipment available, which it properly maintains. And it manages and uses the equipment in ways that protect confidentiality.

Inspector's evidence

The pharmacy had the equipment it needed to provide the services offered. The resources available included the British National Formulary (BNF), the BNF for Children, various pharmacy reference texts and use of the internet. The pharmacy had a set of clean, well maintained measures available for medicines preparation. It kept sensitive information and materials in restricted areas. It positioned computer terminals away from public view. And these were password protected. Pharmacy team members stored medicines waiting to be collected in the dispensary, away from public view. The pharmacy had a dispensary fridge which was in good working order. Pharmacy team members used it to store medicines only. They restricted access to all equipment. And they stored all items securely.

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.