

Registered pharmacy inspection report

Pharmacy Name: Well, 53 Highfield Road, BLACKPOOL, Lancashire,
FY4 2JD

Pharmacy reference: 1033232

Type of pharmacy: Community

Date of inspection: 01/09/2020

Pharmacy context

This is a community pharmacy located on a high street. It is situated in the residential area of South Shore, in Blackpool. The pharmacy dispenses NHS prescriptions, private prescriptions and sells over-the-counter medicines. It also provides a range of services including seasonal flu vaccinations and substance misuse supplies. A number of people receive their medicines in multi-compartment compliance aids.

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	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 team follows written procedures, and this helps to maintain the safety and effectiveness of the pharmacy's services. The pharmacy keeps most of the records it needs to by law. And members of the team are given training so that they know how to keep private information safe. They record things that go wrong and discuss them to help identify learning and reduce the chances of similar mistakes happening again.

Inspector's evidence

There was an electronic set of standard operating procedures (SOPs) which were regularly updated by the head office. Members of the pharmacy team had read and completed online training to indicate they had accepted and understood the SOPs.

The pharmacy had systems in place to identify and manage risk, such as records of dispensing errors and their learning outcomes. An electronic software platform was used to record near miss incidents. At the end of each month this produced a patient safety report which contained the details of any trends identified. The pharmacist said each month he discussed the patient safety report with members of the pharmacy team. He gave examples of the action which had been taken to help prevent similar mistakes, such as highlighting the dispensary locations of common picking errors, for example, pregabalin. The company shared learning between pharmacies by intranet or email messages that gave information about common errors and other possible risks. The pharmacy team would discuss the information when it was received.

Roles and responsibilities of the pharmacy team were described in individual SOPs. Staff were able to explain what their responsibilities were and were clear about the tasks which could or could not be conducted during the absence of a pharmacist. Staff wore standard uniforms and had badges identifying their names and roles. The responsible pharmacist (RP) notice was displayed prominently. The pharmacy had a complaints procedure. A notice in the retail area advised people they could discuss any concerns or feedback with the pharmacy team or head office. Complaints would be recorded and followed up by the pharmacist manager. A current certificate of professional indemnity insurance was available.

Records for the RP, private prescriptions and emergency supplies appeared to be in order. Controlled drugs (CDs) registers were maintained with running balances recorded and generally checked weekly. Two random balances were checked and both found to be accurate. Patient returned CDs were recorded in a separate register. Records of unlicensed specials did not always contain the required details of who the supply was made to, or when the supply was made, so this information may not be available in the event of a concern or query.

An information governance (IG) policy was available. The pharmacy team had received IG training and signed confidentiality agreements. When questioned, the dispenser was able to identify how confidential waste was segregated to be destroyed by a waste carrier. A notice was on display in the retail area about how the pharmacy handled and stored people's information.

Safeguarding procedures were included in the SOPs and the pharmacy team had completed safeguarding training. Pharmacy professional staff had completed level 2 safeguarding training. Contact

details for the local safeguarding board were available. The pharmacy technician said she would initially report any concerns to the pharmacist on duty.

Principle 2 - Staffing ✓ Standards met

Summary findings

There are enough staff to manage the pharmacy's workload and they are appropriately trained for the jobs they do. Members of the pharmacy team complete some additional training to help them keep their knowledge up to date.

Inspector's evidence

The pharmacy team included a relief pharmacist, a pharmacy technician and two dispensers. All members of the team had completed the necessary training for their roles. The normal staffing level was a pharmacist and three other staff. Two members of the pharmacy team would work in a separate dispensing area to assemble compliance aids. Staffing levels were maintained by a staggered holiday system. A relief accuracy checker would sometimes provide additional cover when there were absences during busy periods.

The pharmacy provided members of the team with a structured e-learning training programme based on the company's procedures and services. The training topics appeared relevant to the services provided and those completing the e-learning. Additional training modules were available to help the team's development. But these were not compulsory and were not always completed. So learning and development needs may not always be fully addressed.

The dispenser gave examples of how she would sell a pharmacy only medicine using the WWHAM questioning technique, refuse sales she felt were inappropriate and refer people to the pharmacist if needed. The pharmacist said he felt able to exercise his professional judgement and this was respected by the pharmacy team. The technician said the pharmacy team worked well together, and she was able to ask for further help if she needed it.

Each member of the pharmacy team received regular appraisals. These were used to discuss how well they were performing and whether there were any development needs. And individual risk assessments had been completed for each member of staff about working during coronavirus. Staff were aware of the whistleblowing policy and said that they would be comfortable reporting any concerns to the head office. There were service based targets set for the pharmacy, but the pharmacist said he would only provide these services when it was appropriate.

Principle 3 - Premises ✓ Standards met

Summary findings

The pharmacy premises are suitable for the services provided and steps have been taken to make the premises COVID secure. A consultation room is available to enable private conversations.

Inspector's evidence

The pharmacy was clean, but the workbenches were cluttered with stock waiting to be put away, which reduced the space available to the pharmacy team. An enhanced cleaning regime was in place, with more regular cleaning of high-volume touch points. Floor markings were in place to help encourage social distancing. A sink was available within the dispensary. Customers were not able to view any patient sensitive information due to the position of the dispensary and access was restricted by use of a gate. The temperature was controlled by the use of air conditioning units. Lighting was sufficient. The staff had access to a kitchenette and WC facilities.

A consultation room was available with access restricted by use of a lock. The space was clutter free with a desk, seating, adequate lighting, and a wash basin. The patient entrance to the consultation room was clearly signposted.

Principle 4 - Services ✓ Standards met

Summary findings

The pharmacy's services are easy to access. And it manages and provides them safely. It gets its medicines from recognised sources, stores them appropriately and carries out regular checks to help make sure that they are in good condition. But members of the pharmacy team do not always know when they are handing out higher-risk medicines. So they might not always be able to check that the medicines are still suitable, or give people advice about taking them.

Inspector's evidence

Access to the pharmacy was level via a single door. It was suitable for wheelchair users and there was wheelchair access to the consultation room. Pharmacy practice leaflets gave information about the services offered and information was also available on the website. Pharmacy staff were able to list and explain the services provided by the pharmacy. The pharmacy opening hours were displayed at the entrance and a range of leaflets provided information about various healthcare topics.

The pharmacy had a delivery service. The delivery driver was following the company's updated guidance by providing socially distanced deliveries. A record of delivery was kept, and unsuccessful deliveries would be returned to the pharmacy.

The pharmacy team initialled dispensed by and checked by boxes on dispensing labels to provide an audit trail. They used dispensing baskets to separate individual patients' prescriptions to avoid items being mixed up and the baskets were colour coded to help prioritise dispensing. Owing slips were in use to provide an audit trail if the full quantity could not be immediately supplied. The pharmacist performed a clinical check of all prescriptions and then signed the prescription form to indicate this had been completed. When this had been done an accuracy checker was able to perform the final accuracy check.

Some prescriptions were dispensed by an automated hub as part of the company's central fulfilment programme. Consent to send prescriptions to another site within the company was not routinely obtained. So people may not always know their information is being shared in this way. Prescriptions for the hub were labelled electronically and the pharmacist would then complete the accuracy and clinical check on the information that had been entered. This was then transmitted to the hub, and the PMR indicated any items which could not be dispensed. This included items out of stock, not stocked, or CD and fridge items. The process was auditable by use of a personal log-in to identify who had labelled the prescription and who performed the accuracy and clinical check. Dispensed medicines were received back from the hub within 48 hours bagged for individual patients. These were transported in a sealed tote that clearly identified that it contained dispensed medicines. The bagged medicines were then matched up against the prescription forms and did not need to be accuracy checked by the pharmacist. Any other items not dispensed by the hub were dispensed and checked in the branch.

Dispensed medicines awaiting collection were segregated away from the dispensing area on a collection shelf using a numerical retrieval system. Prescription forms were retained, and stickers were used to clearly identify when fridge or CD safe storage items needed to be added. When people came to collect their medicines, the pharmacy team would search for a patient name on a handheld electronic device. This had a record of the storage location of the person's medicine. Confirmation of the person's address would be obtained by the member of the pharmacy team before they scanned the shelf and the

barcode on the bag. This would need to match the recorded data otherwise a red warning would appear indicating it was the incorrect medicines. This helped to reduce the likelihood of a supply to the incorrect person.

Schedule 3 and 4 CDs were highlighted so that staff could check prescription validity at the time of supply. High-risk medicines (such as warfarin, lithium and methotrexate) were not routinely highlighted. So the pharmacy team were not always aware when they were being handed out in order to check that the supply was suitable for the patient. The staff were aware of the risks associated with the use of valproate during pregnancy. Educational material was available to hand out when the medicines were supplied. The pharmacist said he had completed an audit and would speak to any patients who were at risk to make them aware of the pregnancy prevention programme. But there were currently no patients that met the risk criteria.

Some medicines were dispensed in multi-compartment compliance aids. An assessment was completed by the pharmacist to check if the person was suitable to receive their medicines in a compliance pack. A record sheet was kept for each patient, containing details of their current medication. Any medication changes were confirmed with the GP surgery before the record sheet was amended. Hospital discharge sheets were sought, and previous records were retained for future reference. Disposable equipment was used to provide the service, and the compliance aids were labelled with medication descriptions and a dispensing check audit trail. Patient information leaflets (PILs) were not routinely supplied. So people may not have all of the information they need to take the medicines safely.

The pharmacy offered blistered medication to care homes. A re-order sheet was provided to the pharmacy and it contained details about the medicines required, medicine changes and any handover notes for the pharmacy. When prescriptions were received from the GP surgery they would be compared to the re-order sheet to confirm all medicines had been received back. Any queries were written onto a query sheet and chased up with the GP surgery. A copy of the query sheet was provided to the care home upon delivery of the medicines. Some of the medicines were dispensed into disposable compliance aids and a dispensing and checking signature was written onto the seal. PILs were provided to the care home.

Medicines were obtained from licensed wholesalers, with unlicensed medicines sourced from a specials manufacturer. The pharmacy was not yet meeting the safety features of the falsified medicine directive (FMD), which is now a legal requirement. Equipment was installed but the pharmacy team had yet to commence routine safety checks of medicines. Stock was date checked on a 3-month rotating cycle. Records of what had been checked were electronically maintained. And short dated stock was highlighted using a sticker and recorded for it to be removed at the start of the month of expiry. Liquid medication had the date of opening written on.

Controlled drugs were stored appropriately in the CD cabinet, with some segregation between current stock, patient returns and out of date stock. CD denaturing kits were available for use. There were clean medicines fridges, each with a thermometer. The minimum and maximum temperatures were being recorded daily and records showed they had been in range. Patient returned medication was disposed of in designated bins. Returned medicines were put into plastic bags to help reduced the need to directly handle medicines. Drug alerts were received electronically from the head office. Alerts were actioned and a record was made showing who responded to the alert and when.

Principle 5 - Equipment and facilities ✓ Standards met

Summary findings

The pharmacy's team members have access to the equipment they need for the services they provide. And they maintain the equipment so that it is safe to use.

Inspector's evidence

The staff had access to the internet for general information. This included access to the BNF, BNFc and drug tariff resources. Electrical equipment appeared to be in working order. According to the stickers attached, electrical equipment had been PAT tested in September 2019. There was a selection of liquid measures with British Standard and Crown marks. Separate measures were designated and used for methadone. The pharmacy also had counting triangles for counting loose tablets including a designated tablet triangle for cytotoxic medication. Equipment was kept clean by the pharmacy team.

Clear Perspex screens were installed at the medicine counter. Members of the pharmacy team had access to PPE, such as face masks, visors and gloves. Alcohol gel was also available next to the sinks.

Computers were password protected and screens were positioned so that they weren't visible from the public areas of the pharmacy. A cordless phone was available in the pharmacy which allowed the staff to move to a private area if the phone call warranted privacy. The consultation room was used appropriately; patients were offered its use when requesting advice or when counselling was required. Substance misuse clients were directed to the use of the consultation room to provide privacy.

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.