General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Well, 26-30 Rainhall Road, Barnoldswick, COLNE, Lancashire, BB18 5DR

Pharmacy reference: 1033363

Type of pharmacy: Community

Date of inspection: 19/04/2024

Pharmacy context

This community pharmacy is in a residential area in the village of Barnoldswick, Lancashire. Its main services include dispensing NHS prescriptions and selling over-the-counter medicines. The pharmacy supplies some people with their medicines dispensed 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 not all met

Required Action: Improvement Action Plan

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 not all met	1.2	Standard not met	Pharmacy team members do not adequately learn from mistakes they make when dispensing. This includes not making records of mistakes and not discussing and learning from them to improve patient safety.
2. Staff	Standards not all met	2.1	Standard not met	The pharmacy does not always have a sufficient number of suitably trained team members to manage the dispensing workload safely.
3. Premises	Standards not all met	3.1	Standard not met	Several areas of the pharmacy premises are excessively cluttered and untidy. This increases the risk of a trip or a fall and compromises safe dispensing.
4. Services, including medicines management	Standards not all met	4.3	Standard not met	The pharmacy stores and manages its medicines in a way that increases the risk of mistakes occurring during dispensing. And it does not have effective arrangements to identify, check and remove medicine stock which has expired.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance **Standards not all met**

Summary findings

Pharmacy team members do not keep records of mistakes made during the dispensing process and they do not suitably discuss their mistakes to learn from them. So, they miss opportunities to make the pharmacy's services safer. The pharmacy maintains the records it needs to by law. It suitably protects people's private information, and it adequately supports its team members to help safeguard vulnerable adults and children.

Inspector's evidence

The pharmacy held electronic standard operating procedures (SOPs). A dispenser explained they had read and understood the SOPs that were relevant to their role. The pharmacy's superintendent pharmacist (SI) office reviewed the SOPs every two years. This was to ensure they remained up to date. Team members completed a short assessment after reading each SOP to confirm their understanding.

Pharmacy team members had access to an electronic system to record mistakes made and identified during the dispensing process. These were called near miss errors. Team members explained they didn't have time to record details of near miss errors or discuss them and consider ways to prevent a similar mistake from recurring. And so they may have missed out on the opportunity to learn from mistakes and make changes to ways of working to improve patient safety. The pharmacy had a process for near misses and dispensing incidents to be analysed each month to help identify trends or patterns. However, this process had not been completed for several months. There was no evidence of any learning from mistakes. The pharmacy used the same electronic system to record dispensing incidents where mistakes were identified after people had been supplied their medicines. A dispenser was able to describe the reporting process but was unable to access any historic records.

The pharmacy had a procedure to support people in raising concerns about the pharmacy. It was outlined via a notice displayed in the pharmacy's retail area. Any concerns or complaints were usually raised verbally with a team member. If the team member could not resolve the complaint, it was escalated to the pharmacy's SI team. Team members described how several people who had visited the pharmacy on the day of the inspection had provided negative feedback. This was mainly based on the excessive length of time they had to wait for their prescriptions to be dispensed.

The pharmacy had current professional indemnity insurance. It was displaying a responsible pharmacist (RP) notice which showed the full name and GPhC registration number of the RP on duty. A sample of the RP record inspected was completed correctly. The pharmacy held electronic controlled drug (CD) registers. The balances recorded in the registers were scheduled to be checked against physical stock each week to make sure they matched. A relief dispenser had recently worked at the pharmacy and completed a full balance check of each CD. A random check of two CDs showed that the physical stock matched what the pharmacy had recorded in its registers.

The team held records containing personal identifiable information in areas of the pharmacy that only team members could access. The team placed confidential waste into a separate container to avoid a mix up with general waste. The confidential waste was periodically destroyed via a third-party contractor. Team members understood the importance of securing people's private information. They described how they offered people the use of the pharmacy's consultation room if people felt

uncomfortable discussing their health in the retail area. The team members present during the inspection confirmed they had completed training on General Data Protection Regulation (GDPR). The RP had completed safeguarding training via the Centre for Pharmacy Postgraduate Education (CPPE). Team members were unaware if the pharmacy had a safeguarding reporting policy or procedures, to support them in raising a safeguarding concern.

Principle 2 - Staffing **Standards not all met**

Summary findings

The pharmacy does not always have a sufficient number of suitably skilled team members to manage its services safely and effectively. It provides its team with training material to support them in updating their knowledge and skills. But team members are unable to take the time to complete learning during working hours.

Inspector's evidence

The pharmacy team was working under significant pressure throughout the inspection. The RP was a locum pharmacist who had not worked at the pharmacy previously. The RP was supported by a full-time qualified dispenser and a qualified locum dispenser who had been called to work at the pharmacy for three days during the week of the inspection. The pharmacy employed another full-time, qualified pharmacy assistant who was not present during the inspection. The pharmacy didn't have a regular pharmacist or a manager and had not employed one for several months. The team was significantly behind with its dispensing workload schedule. Prescriptions issued several days before the inspection had not been dispensed. During the inspection several people were observed presenting at the pharmacy expecting to collect their medicines but were asked to wait or come back later while the team dispensed their medicines. Both dispensers were observed completing sales of medicines. They asked appropriate screening questions and involved the RP when necessary to ensure sales were appropriate.

The pharmacy had an online training programme for its team members to use. The programme consisted of several online modules based on healthcare topics and the pharmacy's SOPs. The employed dispenser was aware of the programme but due to workload pressures during the inspection, they were unable to access it. The dispenser confirmed they had not been provided any time to complete any learning for several months.

The pharmacy supplied some people with medicines in multi-compartment compliance packs. The team was due to dispense many of these packs on the day of the inspection to ensure they were ready for people for the next day. Team members explained they felt they would not be able to dispense each pack and would therefore have to dispense some packs when people presented to collect them. Team members accepted this would mean they would be dispensing under time pressures which would increase the risk of mistakes being made. The employed dispenser had worked alone with an RP on one day at the beginning of the week of the inspection. They described this day as highly stressful and several people who used the pharmacy were unhappy with the service they had received. The dispenser was unsure of any additional staffing arrangements having been made for the week after the inspection.

Principle 3 - Premises **Standards not all met**

Summary findings

Some areas of the pharmacy are excessively cluttered and untidy. This increases the risk of a trip or a fall and compromises safe dispensing. The pharmacy is generally clean and it is kept secure. It has a suitable consultation room that people can use to have private conversations with a pharmacy team member.

Inspector's evidence

The dispensary was spacious with several benches used for dispensing. Some benches were cluttered with baskets containing medicines. The RP used a separate bench to complete the final check of prescriptions. The pharmacy had sufficient space to store its medicines however, the dispensary floor was cluttered with boxes containing medicines and retail items that had been delivered to the pharmacy. Some of these items had been delivered to the pharmacy several months ago. The team felt they did not have the time to unpack the boxes and store the medicines on the dispensary shelves. The boxes created a risk of a trip or fall. As many of the retail items had not been unpacked and placed in the retail area for sale, the stock in the retail area was sparse and did not portray a professional image. Several people who used the pharmacy were observed during the inspection asking team members if the pharmacy was permanently closing due to the lack of retail stock being available for them to purchase. The rear of the pharmacy was cluttered with boxes and retail material.

There was a spacious and tidy consultation room available for people to use to have confidential conversations with team members about their health. The pharmacy had separate sinks available for hand washing and for the preparation of medicines. Team members controlled unauthorised access to restricted areas of the pharmacy. Lighting was bright in the dispensary and retail area.

Principle 4 - Services **Standards not all met**

Summary findings

The pharmacy team doesn't store and manage all its medicine as it should. And this increases the risk it may supply some medicines that are not fit for purpose. The team has the knowledge to support people to take their higher-risk medicines safely. And the pharmacy ensures its services are suitably accessible to people.

Inspector's evidence

The pharmacy had level access from the street. Its opening times were clearly advertised. It had the facility to provide large-print labels to help people with a visual impairment. Team members were aware of the Pregnancy Prevention Programme (PPP) for people in the at-risk group who were prescribed valproate, and of the associated risks. They were aware of recently issued legislation to ensure people received valproate in the original manufacturers packaging. The pharmacy advertised various vaccination services via leaflets held in the retail area. However, the pharmacy was not providing these services.

Team members signed the dispensing labels to keep an audit trail of which team member had dispensed and completed a final check of the medicines. They used dispensing baskets to hold prescriptions and medicines together which reduced the risk of them being mixed up. However, much of the pharmacy's recently delivered medicinal stock had not been unpacked from their boxes. Team members were seen picking medicines directly out of the boxes to dispense. This practice further increased the risk of errors being made.

The pharmacy offered a delivery service and kept records of completed deliveries. It had some prescriptions assembled at the pharmacy's offsite hub pharmacy. This process was designed to help reduce the workload pressures on the team. Team members inputted data from each prescription onto the pharmacy's computer system. However, they were often not able to complete this process in a timely manner. As a result, people were presenting at the pharmacy to collect their medicines before the medicines had arrived at the pharmacy from the hub pharmacy. Subsequently, team members regularly needed to recall prescriptions sent to the hub pharmacy and dispense them in the pharmacy while people waited. Team members explained this meant they were often dispensing under time pressures which increased the risk of mistakes being made.

The pharmacy had a process for the team to follow to ensure medicines were within their expiry date before being supplied to people. However, the team was unable to demonstrate any records to confirm when the process had been completed. Team members were not seen checking the expiry dates of medicines during the dispensing process. Seven expired medicines were found following a check of around 30 randomly selected medicines. The expired medicines were brought to the attention of a team member who removed them from the dispensary and gave assurances they would be destroyed following the completion of the inspection. The pharmacy kept most of its prescription-only medicines on shelves and in drawers in the dispensary. These medicines were kept untidily in several areas. Medicines that had similar names or of different strengths were stored on top of each other and not separated. This increased the risk of picking errors being made during the dispensing process. The pharmacy used two clinical-grade fridges for storing medicines that required cold storage. Team members recorded the temperature ranges of the fridges each day. A sample of the records showed

the fridges were operating within the correct temperature ranges.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the appropriately maintained equipment that it needs to provide its services. And it uses its equipment appropriately to help protect people's confidentiality.

Inspector's evidence

The pharmacy used a range of CE marked measuring cylinders. There was a suitable, electronic blood pressure monitor to support the team in measuring people’s blood pressure.The pharmacy stored dispensed medicines in a way that prevented members of the public seeing people's confidential information. It suitably positioned computer screens to ensure people couldn’t see any confidential information. The computers were password protected to prevent any unauthorised access. The pharmacy had cordless phones, so that 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.