General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Well, Stafford House, Main Street, Bentham, LANCASTER, Lancashire, LA2 7HL

Pharmacy reference: 1033392

Type of pharmacy: Community

Date of inspection: 30/06/2022

Pharmacy context

The pharmacy is on a high street in the village of Bentham. Pharmacy team members dispense NHS prescriptions and sell a range of over-the-counter medicines. They provide medicines to people in multi-compartment compliance packs to help them take their medicines correctly. They deliver medicines to people's homes. And they provide people with the NHS New Medicines Service.

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 risks associated with its services. And it has the documented procedures it needs to help it provide services effectively. Pharmacy team members understand their role to help protect vulnerable people. And they suitably protect people's private information. They record and discuss the mistakes they make so that they can learn from them. But they don't always identify why mistakes happen and so they may miss opportunities to make improvements to the pharmacy's services.

Inspector's evidence

The pharmacy had a set of standard operating procedures (SOPs) in place to hep pharmacy team members manage the risks to its services. These were available electronically. During the inspection, some pharmacy team members found it difficult to find the SOPs on the company's intranet system. 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 they completed a test after reading each one. If they passed the test, they could complete the sign off process as having read and understood it. The pharmacy defined the roles of pharmacy team members in each SOP, and tasks were further defined by frequent discussions amongst pharmacy team members throughout the day. The pharmacy received a bulletin approximately every month from the company's professional standards team, called "Share and Learn", communicating professional issues and learning from across the organisation because of near miss and error analysis. The bulletin also provided best practice guidance on various topics and case studies based on real incidents that had occurred. It detailed how pharmacy team members could learn from these. Pharmacy team members read the bulletin and signed the front of each bulletin to record that they had done so.

Pharmacy team members highlighted and recorded near miss and dispensing errors they made when dispensing. There were documented procedures to help them do this effectively. They discussed their errors and why they might have happened. And they used this information to make some changes to help prevent the same or similar mistakes from happening again. One example of changes they had made was separating look-alike and sound-alike (LASA) medicines on the shelves, to help prevent the wrong medicines being selected. Pharmacy team members did not always capture much information about why the mistakes had been made or the changes to prevent a recurrence to help aid future learning. But they gave their assurance that these details were always discussed. The pharmacy manager analysed the data collected every month to look for patterns. They recorded their analysis. And pharmacy team members discussed the patterns found at a monthly patient safety briefing. Recent analyses had identified that team members were most commonly making quantity errors. But they had not changed anything specific to help prevent quantity errors being made. This was discussed. And team members highlighted that they were often distracted and interrupted while they were dispensing to speak to someone at the pharmacy counter. Or answer the telephone. Pharmacy team members gave their assurance they would discuss distractions further. And identify where they could make changes to help prevent distractions causing errors.

The pharmacy had a documented procedure in place for handling complaints or feedback from people. Pharmacy team members explained feedback was usually collected verbally and by using

questionnaires given to people at the pharmacy counter. Any complaints were immediately referred to the pharmacist to handle. The pharmacy had a practice leaflet available, which included information for people about how to provide the pharmacy with feedback.

The pharmacy had up-to-date professional indemnity insurance in place. It kept controlled drug (CD) registers electronically, and these were complete, with running balances in all registers. Pharmacy team members audited these registers against the physical stock quantity every week. The pharmacy kept and maintained a register of CDs returned by people for destruction. And it was complete and up to date. The pharmacy maintained a responsible pharmacist record. And this was also 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 accurate private prescription and emergency supply records.

The pharmacy kept sensitive information and materials in restricted areas. It collected confidential waste in dedicated bags. These bags were sealed when full and collected periodically by a waste disposal contractor for secure destruction. The pharmacy had a documented procedure in place to help pharmacy team members manage sensitive information. Pharmacy team members had signed to confirm they had understood the procedure. Pharmacy team members explained how important it was to protect people's privacy and how they would protect confidentiality. And they completed mandatory training each year. A pharmacy team member gave some examples of symptoms that would raise their concerns about vulnerable children and adults. And how they would refer to the pharmacist. The pharmacy had procedures for dealing with concerns about children and vulnerable adults. The pharmacist had last completed safeguarding training 2020. But other pharmacy team members could not access the electronic system during the inspection to determine when they had last completed training.

Principle 2 - Staffing ✔ Standards met

Summary findings

Members of the pharmacy team are suitably qualified for their roles and the services they provide. And they complete ongoing training to keep their knowledge and skills up to date. The pharmacy has just enough team members to manage the workload, but they often find it difficult to manage distractions effectively. This may increase the risk of them making mistakes.

Inspector's evidence

During the inspection, the pharmacy team members present were the responsible pharmacist (RP) manager and two dispensers. Pharmacy team members were working without pause or respite during the inspection. And they often found it difficult to allow time to speak to the inspector. Pharmacy team members were continually distracted and broken off from their dispensing activities to serve people at the pharmacy counter and answer queries from people. And to answer the telephone. Pharmacy team members managed the workload to the best of their capacity.

Pharmacy team members completed mandatory e-learning modules ad hoc when sent by head office. These also included any new or updated standard operating procedures. Pharmacy team members also regularly discussed learning topics informally and the pharmacist highlighted topics for team members to learn more about. They sometimes took time during work to complete mandatory training. But they explained it was difficult to find time at work to complete training. So, often they completed training at home in their own time. Pharmacy team members received an appraisal with the pharmacy manager twice a year. They had a meeting with the manager to monitor their progress, allowing them to reflect on their own performance and identify their own learning needs. The manager explained the team were behind with appraisals because of staff shortages and the lack of available time to complete them. But they gave their assurance that this was a priority for them to complete as soon as possible.

Pharmacy team members explained they would usually raise professional concerns with their area operations manager (AOM) or regional operations manager. But currently, both positions were vacant, with another AOM from elsewhere covering their area as well as their own. Pharmacy team members explained this sometimes made it difficult to raise issues and concerns. But they felt comfortable raising concerns. They were less confident that their concerns would be considered, or changes made to help them improve. The pharmacy had a whistleblowing policy. Pharmacy team members communicated with an open working dialogue during the inspection. They explained they felt comfortable suggesting areas for improvement in the pharmacy. And these would be raised informally amongst the team.

The manager explained the company set the team targets to achieve in various areas of the business. These included number of prescriptions items dispensed, the services they provided, and the number of people nominated to use the pharmacy to have their electronic prescriptions dispensed. The manager explained the team were given autonomy to manage their targets appropriately.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean and properly maintained. It mostly provides a suitable space for the services provided. But some of the dispensary benches are cluttered, which limits the available workspace. This makes the dispensing operation less effective and could increase the risk of error. The pharmacy has a suitable room where people can speak to pharmacy team members privately.

Inspector's evidence

The pharmacy was clean and well maintained. The pharmacy was small and there was a limited amount of bench space available to prepare prescriptions. Most benches were tidy and well organised. Some were cluttered with prescription baskets and medicines waiting to be dispensed. But pharmacy team members organised their work clearly and with a logical workflow. The pharmacy's floors and passageways were generally free from clutter and obstruction. 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 deliver services and have private conversations with people.
There was a clean, well-maintained sink in the dispensary used for medicines preparation. There was a toilet, with a sink which provided hot and cold running water and other facilities for hand washing. The pharmacy maintained heat and light to acceptable levels. Its overall appearance was professional and suitable for the services it provided.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy’s services are accessible to people, including people using wheelchairs. Team members manage the pharmacy's services and available technology well to make sure people quickly receive the right care. The pharmacy sources its medicines appropriately. And it stores medicines properly. It has systems in place to help provide its services safely and effectively and to manage its medicines appropriately. But team members don’t always follow the correct procedure to help prevent people being supplied with out-of-date medicines.

Inspector's evidence

The pharmacy had level access from the street through automatic doors. Pharmacy team members explained how they would communicate in writing with people with a hearing impairment. And provide large-print labels and instruction sheets to help people with a visual impairment.

The pharmacy provided advice to people about new medicines they had been prescribed as part of the NHS New Medicines service. Pharmacy team members had been trained to help identify people who had been prescribed new medicines. And the pharmacy’s electronic records system helped do this effectively. They referred people to the pharmacist to have a consultation about their new medicines and any newly diagnosed conditions. The pharmacist gave an example of someone who had received a consultation because they had recently been diagnosed with atrial fibrillation and heart failure. During the consultation, the pharmacist established the person lived alone and was worried about their new condition and the medicines they needed to take. The pharmacist provided them with advice and information to help them manage their condition. And was able to provide them with close support over a period of weeks to help them manage their new medicines properly. Pharmacy team members had also recently identified someone suffering from severe cellulitis during a conversation with them when they came to the pharmacy looking for health supplements. The pharmacy had an established good working relationship with the local GP practice. So, the pharmacist was able to refer the person for an urgent GP appointment.

The pharmacy had a good proportion of its prescriptions dispensed at the company's off-site dispensing hub, where medicines were picked and assembled by a dispensing robot. Pharmacy team members explained that prescriptions were assessed to establish whether they were suitable to be sent to the hub. They continued to dispense prescriptions for urgent acute items, such as antibiotics, for medicines stored in the fridge and for prescriptions for unusual quantities of medicines. They used the hub most commonly for people's regular repeat medication. 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. The pharmacist logged on to the system and performed a clinical and accuracy check of each prescription. Once the pharmacist was satisfied, they released the prescription which was then sent to the hub for assembly. The pharmacy received the medicines in sealed packages from the hub. Pharmacy team members married up the bags with the relevant prescriptions and any medicines that had already been prepared in the pharmacy. And the bags were added to the prescription retrieval shelves ready for collection or delivery.

Pharmacy team members explained a change to the way they ordered medicines for prescriptions. Previously, stock had been ordered according to data about prescribed medicines and their quantities

each month. And these medicines were put away before prescriptions waiting for items were dispensed. Now, most medicines were ordered specifically for the prescriptions received. Pharmacy team members then dispensed prescriptions immediately from the stock received the following day. And the stock arrived in dedicated totes that only contained these medicines. Pharmacy team members said the new system helped them to dispense items waiting for stock more quickly for people. And the system reduced the risk of picking errors. They explained that the risk was reduced because it was likely that the stock order only contained the medicines they had ordered, in the correct form and strength. They explained that when picking from the shelves, there was more risk of them picking the wrong strength of the same medicine or a different similarly named or packaged medicine by mistake.

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.

Pharmacy team members signed the 'dispensed by' and 'checked by' boxes on dispensing labels during dispensing. This was to maintain an audit trail of the people involved in the dispensing process. They used dispensing baskets throughout the dispensing process to help prevent prescriptions being mixed up. The pharmacist counselled people receiving prescriptions for valproate if appropriate. And they checked if the person was aware of the risks if they became pregnant while taking the medicine. They advised they would also check if they were on a pregnancy prevention programme. The pharmacy had stock of information materials to give to people to help them manage the risks of taking valproate. A dispenser was observed asking the pharmacist about a request from someone to by a medicine containing codeine over the counter. The dispenser had questioned the person appropriately and was able to clearly provide this information to the pharmacist to determine whether the supply would be safe and appropriate.

The pharmacy supplied medicines to people in multi-compartment compliance packs when requested. It attached backing sheets to the packs, so people had written instructions of how to take their medicines. Pharmacy team members included descriptions of what the medicines looked like, so they could be identified in the pack. And they provided people with patient information leaflets about their medicines each month. Pharmacy team members documented any changes to medicines provided in packs on the person’s master record sheet, which was a record of all their medicines and where they were placed in the packs. The pharmacy delivered medicines to people’s homes. It used an electronic system to compile a list of the deliveries which was uploaded to the delivery driver’s hand-held device. The driver also used the device to determine the most efficient route to take. The system allowed pharmacy team members to track the delivery driver’s progress throughout their delivery run. And this helped them to locate prescriptions and resolve queries from people who telephoned the pharmacy. The information uploaded to the driver’s device included detail about each prescription, such as the presence of an item that needed to be stored in a fridge. or a controlled drug. The delivery driver left a card through the letterbox if someone was not at home when they delivered, asking them to contact the pharmacy. They automatically attempted to deliver a second time on their next delivery run. They highlighted any deliveries that had failed twice to pharmacy team members. And team members made

enquires to help make sure people received their medicines.

The pharmacy obtained medicines from licensed wholesalers. It stored medicines on shelves and in drawers. The pharmacy had disposal facilities available for unwanted medicines, including CDs. Pharmacy team members monitored the minimum and maximum temperatures in the pharmacy's fridges each day and recorded their findings. The temperature records seen were within acceptable limits. Pharmacy team members recorded checks of medicine expiry dates that they made in various areas of the pharmacy every month on a rolling cycle. This meant they checked all medicines every three months. But pharmacy team members were behind with their checks. Pharmacy team members highlighted and recorded any short-dated items up to three months before their expiry. These items were removed from the shelves at the next scheduled date check, even if they had expired before that. This was not in accordance with the company's standard operating procedure for checking medicines expiry dates. This was discussed. Pharmacy team members explained they were behind because of staff shortages and not having time to carry out the necessary checks. They also explained they did not use the electronic system available to record and monitor short-dated items. But they gave their assurance that they check medicines expiry dates while they dispensed them. And when the pharmacist performed their final accuracy checks of a prescription. The inspector did not find any out-of-date medicines on the shelves. And there were no recorded near miss and dispensing errors that involved out-of-date medicines.

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 people's confidentiality.

Inspector's evidence

The pharmacy had the equipment it needed to provide the services offered. The resources it had 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 had suitable bags available to collect and segregate its confidential waste. It kept its password-protected computer terminals in the secure areas of the pharmacy, away from public view.

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.