General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Well, New Surgery, Exeter Street, BOURNE, Lincolnshire, PE10 9NJ

Pharmacy reference: 1034247

Type of pharmacy: Community

Date of inspection: 09/04/2024

Pharmacy context

The pharmacy is next to a GP surgery in the historic market town of Bourne, Lincolnshire. Its main services include dispensing NHS prescriptions and selling over-the-counter medicines. The pharmacy offers a seasonal flu and COVID-19 vaccination services. It provides a range of NHS advanced services including the New Medicine Service, Contraception Service, Hypertension Case-Finding Service, and the NHS England Pharmacy First Service. It supplies some medicines in multi-compartment compliance packs designed to help people remember to take their medicines. And it offers a medicine delivery service 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 met	N/A	N/A	N/A
2. Staff	Standards not all met	2.1	Standard not met	The pharmacy does not always have enough suitably trained staff to operate safely and effectively. The pharmacy team is behind with its dispensing activities. And team members are struggling to complete some pharmacy records and follow processes for ensuring medicines are safe to supply.
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

Overall, the pharmacy manages the risks for the services it provides. It keeps most of its records as required by law and it keeps people's confidential information safe. Its team members respond to feedback from people using the pharmacy's services appropriately. And they know how to recognise and report safeguarding concerns to help keep vulnerable people safe from harm. Pharmacy team members make some records of the mistakes they during the dispensing process. But they are missing opportunities to learn from these mistakes due to workplace pressures.

Inspector's evidence

The pharmacy had standard operating procedures (SOPs) to support its safe and effective running. Its superintendent pharmacist's team reviewed these on a rolling two-year rota. And it introduced SOPs ahead of new services commencing. Team members accessed the SOPs electronically. Training records showed that some team members had outstanding learning required for some of the SOPs. The responsible pharmacist (RP) was the pharmacy manager, they had worked for the company for around six months and was new to the manager role. They had committed time to learning the company's processes but still needed to complete some formal learning for the SOPs. Team members were observed completing most tasks in accordance with SOPs. A team member discussed their role and had a clear understanding of what tasks could not take place when the RP took absence from the pharmacy.

The pharmacy had tools to support its team members in learning from mistakes. Pharmacy team members corrected mistakes brought to their attention during the dispensing process, known as near misses. The RP recorded most near misses. But they did not always record mistakes involving labelling errors to support the team in learning from these. The pharmacy reported mistakes identified after a medicine was supplied to a person, known as dispensing incidents. These reports showed the actions the team took to reduce risk. But the pharmacy did not always complete actions such as team briefings in a timely manner following these types of mistakes. And the team did not take regular opportunities to share learning through structured patient safety reviews. This meant there was an increased chance of the same mistake happening again.

The pharmacy advertised its complaints procedure. A team member discussed how they would manage feedback and respond to concerns. They knew how to refer people to the pharmacy's head office should they wish to escalate a concern. The team felt feedback had increased over the last year due to increased waiting times and medicines not being ready for people to collect when they attended the pharmacy. It had noticed a fall in the number of people accessing its services within this time. Pharmacy team members completed mandatory learning about data security and confidentiality. They stored all confidential information in staff-only areas of the pharmacy. And they followed secure processes when disposing of confidential waste. Pharmacy team members completed learning about safeguarding vulnerable people. They had access to procedures and contact information for local safeguarding teams. A team member confidently explained how they would recognise and report concerns with support from their manager. And they had a good understanding of safeguarding initiatives promoted by domestic violence charities designed to support people experiencing domestic violence in accessing a safe space.

The RP notice displayed the correct details of the RP on duty. The RP record was completed in full. The pharmacy kept its controlled drug (CD) register electronically. The team did not always enter the address of the wholesaler when recording receipt of a CD. The pharmacy team carried out regular balance checks of physical stock against balances recorded in the CD register. The RP had acted to ensure these were being completed in accordance with the pharmacy's SOPs following feedback from their area operation manager. The pharmacy kept a record of patient-returned CDs. But it did not always record the receipt of these medicines at the time it received these returns. The RP provided confirmation they had acted to make a record of a returned CD held in the CD cabinet shortly after the inspection took place. The pharmacy team kept records for the unlicensed medicines it dispensed in good order. But it did not complete record keeping tasks for the private prescriptions it dispensed in a timely manner. Prescriptions dating back six weeks were waiting to be entered into the register. And records for some private prescriptions, filed as complete could not be found.

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

Summary findings

There are not enough suitably qualified team members available to support the safe and effective delivery of pharmacy services. Pharmacy team members are struggling to keep up with dispensing tasks. And they do not complete other essential tasks to support the safe supply of medicines. Pharmacy team members engage in learning relevant to their role. And they feel able to provide feedback at work.

Inspector's evidence

The RP was working alongside a qualified dispenser as the inspection began. A trainee dispenser joined the team shortly after midday. The team reported that this level of cover was normal across several days each week. The pharmacy employed another trainee dispenser, this team member had been on long-term leave for over four months. The team explained there was no regular scheduled support from the area relief team to cover this leave. Support was provided to cover annual leave and ad-hoc when the team made specific requests. A new company-employed driver had commenced their role the day prior to inspection.

The pharmacy transferred 77% of dispensing workload to the company's dispensing hub pharmacy. This was designed to support the team in managing its services. But the team was currently a week behind with completing dispensing tasks. They reported that there had been several days within the last month when there had been only one team member and the RP on duty. The dispenser was the only team member trained to complete tasks for the multi-compartment compliance pack service. The team worked well to plan this workload into its daily routine. But this led to times when the RP covered the medicine counter and self-checked their own dispensing. The RP described how they had managed this and had asked the second team member to double check their work before they conducted the final accuracy check whenever possible. This way of working was impacting the RP's ability to safely keep up with accuracy checking tasks. There was no lone working on the premises. A team member reported that the pharmacy had needed to report some unplanned closures to the NHS between 5pm and 6pm as there had not been enough team members to safely provide the pharmacy's services. Pharmacy team members expressed concern about the impact on workload of a seasonal COVID-19 vaccination service due to start later in April. The pharmacy had some targets for the services it provided. And the RP discussed how they felt able to apply their professional judgment when providing the pharmacy's services.

The trainee dispenser felt supported in their role and they were confident in asking questions to support their learning. They did not receive protected learning time at work and team members reported additional pressures due to the current skill mix of pharmacy support staff. Team members completed mandatory e-learning to support them in their roles in their own time. Pharmacy team members engaged in discussions at work to support them in managing workload. But the team had not taken engaged in structured meetings such as patient safety reviews. This meant there were missed opportunities to share learning. The pharmacy had a whistleblowing policy and team members knew how to provide feedback and report concerns at work. The team stated it had recently highlighted some of the work pressures it was experiencing. And team members were aware the company had recently recruited for additional area relief dispensers.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are appropriately secure and clean. They offer a suitable environment for providing pharmacy services. People accessing the pharmacy can speak to a member of the team in a private consultation room.

Inspector's evidence

The pharmacy was secure, clean, and maintained to an acceptable standard. Team members knew how to report maintenance concerns. Lighting was sufficient throughout the premises and air conditioning helped to provide an ambient temperature. Team members had access to handwashing facilities including sinks equipped with antibacterial hand wash and paper towels.

The pharmacy's public area was relatively open plan. A private consultation room led off this area. The room was professional in appearance and contained equipment to support the efficient delivery of consultation services. The dispensary was large, and the team used the space well to manage its workload. For example, the RP had their own workspace at the front of the dispensary. And a team member completed higher risk tasks such as assembling medicines in multi-compartment compliance packs on a workbench at the back of the dispensary. A workbench running the length of the dispensary contained stacked baskets containing medicines and prescriptions. There was ample space available for completing dispensing tasks despite this backlog of work. To the side of the dispensary was a corridor leading to some storage space and staff facilities.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's services are generally accessible to people. It obtains its medicines from reputable suppliers. And it stores its medicines safely and securely. Pharmacy team members mostly use audit trails to support them in managing queries that may arise when providing pharmacy services. They carry out checks during the dispensing process to ensure medicines are in good condition and are suitable to supply to people.

Inspector's evidence

The pharmacy was accessed from street level with onsite parking available. It advertised its opening times and details of the pharmacy services it provided. Pharmacy team members knew how to signpost people to another pharmacy or healthcare provider in the event people required a service or medicine which the pharmacy could not provide. The pharmacy stored its Pharmacy (P) medicines behind its medicine counter. And the RP had good supervision of activity taking place at the medicine counter. The RP accessed current information to support them in managing the pharmacy's consultation services safely. This information included service specifications, patient group directions (PGDs) and clinical pathways. The RP had completed relevant learning ahead of conducting these services. They were currently behind with some record keeping tasks for the NHS New Medicine Service.

The pharmacy team understood the requirements of the valproate Pregnancy Prevention Programme (PPP). But they were not fully aware of recent legal changes requiring the supply of valproate only in the manufacturer's original packaging. A discussion highlighted the need to comply with these legal changes. The pharmacy did not currently dispense valproate to people in the at-risk group. The RP was fully aware of the counselling requirements if they were required to supply valproate to people in the at-risk group. The RP provided examples of counselling they provided when dispensing higher-risk medicines. This included encouraging people to share monitoring records with the pharmacy and exploring potential side effects of these medicines and what to do if they noticed these side effects. But they did not take the opportunity to record these types of interventions on people's patient medication record (PMR) to support continual care.

The pharmacy used coloured baskets throughout the dispensing process. This kept medicines with the correct prescription form and helped inform workload priority. It kept original prescriptions for medicines owing to people. But it was behind with processing these prescriptions due to the workload pressures. This meant people often had to wait when returning to pick up medicines owed to them. The pharmacy maintained an audit trail of the medicines it delivered to people's homes. The offsite dispensing process involved the team securely transferring data from people's prescriptions to the dispensing hub pharmacy. This data was checked for accuracy by the RP, the RP also completed clinical checks of all prescriptions, including those sent to the dispensing hub pharmacy. The hub dispensed the prescription and sent the medicine back to the pharmacy to be collected by or delivered to people. Pharmacy team members demonstrated how they safely managed dispensing activity when part of the prescription was dispensed at the hub and part was dispensed in the pharmacy. The backlog of work observed largely consisted of part-assembled prescriptions returned from the hub waiting for other items to be dispensed locally. The company shared operation guidance that supported team members in following its SOPs. This guidance promoted completing local dispensing tasks ahead of medicines

being received back from the hub rather than afterwards.

Pharmacy team members took ownership of their work by applying their dispensing signatures within the ‘dispensed by’ and ‘checked by’ boxes on medicine labels. The pharmacy dispensed medicines to people residing in a care home. It supplied these medicines in original packaging and provided medication administration record (MAR) sheets to the care home to support its team in administering the medicines safely. There were some current communication issues between the pharmacy and care home due to access issues with the pharmacy's NHS email account. This made it more difficult for the pharmacy to ensure it had received prescriptions for all medicines ordered by the care home. And meant the team had to communicate with care home staff by telephone. The pharmacy had a schedule to support it in supplying medicines in multi-compartment compliance packs to people. It benefitted from a good working relationship with the local surgery with regular face-to-face communication with prescription clerks to support in managing changes to people’s medicine regimens. And it clearly recorded these changes within ‘event diaries’ kept with people’s individual records. A sample of assembled compliance packs contained descriptions of the medicines inside them. But the team did not physically attach backing sheets to the compliance packs securely. The pharmacy routinely supplied patient information leaflets alongside compliance packs at the beginning of each four-week cycle.

The pharmacy sourced medicines from licensed wholesalers and specials manufacturers. It stored medicines in a relatively orderly manner, within their original packaging. The pharmacy stored CDs neatly within a secure cabinet. It stored medicines requiring refrigeration in medical fridges. It monitored and recorded the operating temperature range of these fridges. It kept temperature records for the fridges which showed it was storing these medicines within the required temperature range of two and eight degrees Celsius.

The pharmacy team had not completed any routine tasks to support it in identifying expired medicines or those not suitable to supply to people within the last three months. They were aware this was not in keeping with the pharmacy’s procedures which required team members to check sections of the dispensary monthly on a rolling rota. The team explained there had not been time to undertake these checks due to the backlog of dispensing work. Team members instead were actively checking medicine expiry dates during the dispensing process. A random check of dispensary stock found two date-expired medicines. These were brought to the attention of the RP for safe disposal. The pharmacy had appropriate medicine waste bins, sharps bins and CD denaturing kits available. It received details of drug alerts electronically and completed an audit trail to show it was responding in a timely manner to these alerts.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment in needs to provide its services. And its team take appropriate steps to protect people's confidentiality when using the equipment.

Inspector's evidence

The pharmacy stored bags of assembled medicines safely in a designated area of the dispensary. This suitably protected personal information on prescriptions and bag labels from unauthorised view. It positioned its computer monitors appropriately to protect information on screen. Pharmacy team members used passwords to access people's medication records and most team members had working NHS smartcards. The RP had recently completed a process to support them in ensuring all team members had working NHS smartcards. Pharmacy team members used a cordless telephone handset and moved out of earshot of the public area when discussing confidential information over the telephone.

Team members had access to some relevant hard copy reference resources, and they had access to a wide variety of digital reference resources to support them in obtaining information. The pharmacy team used crown-stamped measuring cylinders when measuring liquid medicines and they used clean counting equipment for counting tablets and capsules. A range of equipment in the pharmacy's consultation room was from recognised manufacturers. The pharmacy had monitoring processes to ensure its equipment remained safe to use. And its electrical equipment was subject to periodic safety checks.

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.