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: 10/10/2024

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 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 effectively identifies and manages the risks for providing its services. It keeps people's confidential information secure. And it maintains its records as required by law. The pharmacy uses feedback from people to inform how it provides its services. Pharmacy team members know how to recognise, and report concerns to help protect vulnerable people. They behave openly and honestly by engaging in regular reviews following mistakes. And they act appropriately to reduce risk following these mistakes.

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. The RP was the pharmacy manager, they had oversight of the teams training records. And they demonstrated how learning was kept under review to help ensure all team members kept up to date with the SOPs. Two new team members had recently joined the team and good progress was being made to support them in completing learning relevant to their roles. One of the new team members was on duty and they took the opportunity to discuss their role and they felt comfortable escalating a query to an experienced team member when required. For example, the regular pharmacist had not taken absence from the pharmacy since the team member had started. They explained they had learnt about RP absence but would check with the dispenser on duty should this situation occur to ensure they managed tasks appropriately during this time. The relief dispenser had a clear understanding of what tasks couldn't take place should the RP take absence.

Pharmacy team members received feedback about the mistakes they made when dispensing medicines. They acted to correct the mistakes identified during the dispensing process, known as a near misses. And they recorded their own mistakes whenever possible. The team also recorded mistakes made and identified following the supply of a medicine, known as dispensing incidents. The RP led a patient safety review process each month which identified trends in mistakes. The team used this information to share learning and to inform any risk reduction actions required. For example, separating medicines with similar names and completing stock management tasks to help ensure medicines were stored neatly on the dispensary shelves to help reduce the risk of picking errors occurring. Team members also reflected on their mistakes and identified changes to their own practice to reduce the risk of a mistake occurring during the patient safety review. For example, the team had acted to reduce situations where the RP was solely involved in both the assembly and accuracy check of a medicine. The RP was observed asking the dispenser to complete a second check of a medicine they had assembled when providing a consultation service during the inspection.

The pharmacy advertised how people could provide feedback about its services. A team member discussed how they would manage feedback and respond to concerns. The RP regularly reviewed the feedback the pharmacy received. And they provided an example of how they had acted on feedback posted on the internet about the pharmacy to help improve people's experiences of visiting the pharmacy for a vaccination. Pharmacy team members completed learning about safeguarding vulnerable people. The RP provided evidence of level three safeguarding learning they had completed

prior to offering some of the pharmacy's consultation services. Team members knew how to recognise and report these types of concerns. And they had access to contact information for local safeguarding teams. The pharmacy advertised its consultation room as a safe space. And team members understood how to respond to requests to use this space.

Pharmacy team members completed mandatory learning about data security and confidentiality. The trainee team member was aware of the importance of keeping people's personal information secure. The relief dispenser on duty was observed making appropriate checks prior to confirming information about a person's medication regimen with a hospital pharmacy department. The team stored all confidential information in staff-only areas of the pharmacy. And they followed secure processes when disposing of confidential waste. The RP notice displayed the correct details of the RP on duty. Samples of the RP record, specials records, private prescription register, and controlled drug (CD) register found records were made in accordance with legal and regulatory requirements. The pharmacy had recently switched its electronic CD register and private prescription register provider. It had access to archived records from its previous provider in case any queries arose. The pharmacy team carried out regular balance checks of physical stock against balances recorded in the CD register. Physical balance checks completed during the inspection matched the balances within the CD register. The team made a record of patient-returned CDs at the time of receipt.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy employs a team of people with the knowledge and skills required to provide pharmacy services safely and effectively. Team members work together well and are supportive of each other. They take regular opportunities to share learning at work. And they know how to provide feedback and raise concerns.

Inspector's evidence

On duty was the RP, a relief dispenser, and a trainee team member. The pharmacy also employed another trainee and a qualified dispenser. A company employed delivery driver provided the medicine delivery service. The company had reviewed staffing levels and skill mix since the last inspection in April 2024. This review had led to ensuring relief support was regularly available should a team member be absent from work. The team demonstrated how it was managing its work well and the RP expressed feeling supported in their role and able to balance workload in the dispensary with providing consultation services. The relief dispenser had a good understanding of how the pharmacy operated. They were observed managing queries and sharing information with the regular team. This allowed the RP to complete the morning's vaccination appointments with minimal interruption.

Two trainee dispensers had left the pharmacy recently, and two new team members were working through a formal induction. They received some time at work to support them in their learning, and also chose to complete some learning at home. A delivery driver was also observed speaking to the RP about their GPhC accredited training course. In response to the skill mix review, it had enrolled the dispenser on an accuracy checking assistant course. And the team understood how this would support workflow long term. Having relief team members available to cover absence meant one team member was readily available to undertake tasks at the medicine counter. The RP explained this had made a significant difference to their ability to remain up to date with dispensary tasks and it had reduced workload pressure effectively.

The pharmacy had some targets for the services it provided. The RP demonstrated how the team worked to identify people who were eligible for NHS consultation services during the dispensing process. And they felt able to apply their professional judgment when completing pharmacy services. Team members took regular opportunities to share learning with each other through conversation. This learning included discussing information within the patient safety reports and exploring patient safety case studies. The pharmacy had a whistle blowing policy and team members had access to a confidential employee assistance programme. A team member knew how to raise a concern at work and understood how to escalate a concern should they need to.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are suitably secure and clean. They offer a professional 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 appropriate standard. Team members knew how to report maintenance concerns and were not aware of any outstanding concerns. Lighting was sufficient throughout the premises and air conditioning helped to control the temperature year-round. 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 it contained equipment to support the delivery of consultation services. The dispensary was large. It was split into two sections, a small lower level just beyond the medicine counter was used by the pharmacist. This allowed them to supervise activity at the medicine counter and in the public area with ease. A few steps led to the upper level of the dispensary. This provided good space for managing labelling and assembly tasks. A team member used an area at the back of the dispensary to complete tasks for the multi-compartment compliance pack service, this provided protected space for this higher-risk activity. 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 provides people with information to support them in accessing its services. It obtains medicines from reputable sources, and it stores them safely and securely. Its team members make regular checks to ensure medicines are safe to supply to people. And they effectively record the advice and support they provide to people to help them take their medicines safely.

Inspector's evidence

The pharmacy was accessed from street level with onsite parking available. It advertised its opening times and details of the services it provided. A notice on the door provided people with timings of the flu and COVID vaccination clinics. The notice explained that people visiting the pharmacy during these times may experience some extra waiting time. And it encouraged people wishing to speak to the pharmacist to attend outside of clinic hours, if possible, to prevent them needing to wait longer than normal. 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. Pharmacy team members understood the need to refer repeat requests for higher-risk P medicines liable to abuse to the RP. The team had relevant information available to support the safe delivery of its consultation services. This included service specifications and SOPs and patient group directions (PGDs) to support pharmacists in making supplies of medicines. And team members could access information such as risk assessments completed by its SI team to support it in providing these services. The RP made effective and timely records of the consultations and any medicines supplied through the consultation services.

The team identified higher-risk medicines during the dispensing process. The RP demonstrated their approach to counselling people when handing out these medicines. And they had a good range of tools to support them with their approach. For example, patient guides and monitoring booklets. The RP recorded details of the interventions they made when handing out these medicines. They discussed the requirements of medicine-related pregnancy prevention programmes (PPPs) and they explained how they had applied recent changes to their practice to ensure they identified opportunities to provide men taking valproate with advice following a recent update to the valproate PPP.

The pharmacy used coloured baskets throughout the dispensing process. This kept medicines with the correct prescription form and helped inform workload priority. 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 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. A team member from the local surgery was observed providing a face-to-face handover of a person’s medication needs to the team during the inspection. The team recorded changes to people’s medicine regimens within ‘event diaries’ kept with people’s individual records. A sample of assembled compliance packs contained descriptions of the medicines inside them. And patient information leaflets were provided alongside compliance packs at the beginning of each four-week cycle. The pharmacy kept original prescriptions for medicines it owed to people. Team members made regular checks of these prescriptions and informed people if they needed to speak with their

prescriber due to a medicine not being available. The pharmacy maintained an audit trail of the medicines it delivered to people's homes through using a digital application.

The team sent some prescription data to the company's offsite dispensing hub pharmacy for medicines assembly. It used barcode technology throughout this process to help track prescriptions and assembled medicines. The RP provided examples of the checks they made when checking the accuracy of data ahead of sending it to the dispensing hub pharmacy. And they demonstrated the information they had to support them in completing the clinical check of prescriptions. For example, details of interactions and identification of new medicines flagged by the patient medication record system. The team ordered any medicines requiring local dispensing when submitting the data to the dispensing hub pharmacy. It took care to identify part-complete prescriptions when they returned from the hub by holding these in individual baskets with any medicines requiring dispensing locally. The dispenser demonstrated how this helped to ensure both bags of assembled medicines were scanned to the designated holding area together which reduced the risk of a person only being supplied with part of their prescription.

The pharmacy sourced medicines from licensed wholesalers and a licensed specials manufacturer. It stored its medicines neatly within their original packaging. The pharmacy stored CDs in an orderly manner within a secure cabinet. It used different areas of the cabinet for storing assembled medicines awaiting collection and medicines returned by people. The pharmacy had four pharmaceutical fridges for storing medicines requiring cold storage. 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 completed regular stock management checks, including checking expiry dates of medicines. It had several tasks from September 2024 awaiting completion. The relief dispenser was aware of this and was actively working to complete these tasks. The team identified short-dated medicines clearly and it recorded the opening date on bottles of liquid medicines to ensure they were safe to supply to people. A random check of dispensary stock found no out-of-date medicines. The pharmacy had appropriate medicine waste bins and bags, sharps bins and CD denaturing kits available. It received details of drug alerts and medicine recalls electronically through a task tracker. It kept local copies of these alerts to refer to and it completed an audit trail of the checks made in response the alerts.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

Pharmacy team members use appropriate equipment and facilities which protect people's confidentiality when providing pharmacy services. And the pharmacy suitably maintains its equipment to ensure it is safe to use.

Inspector's evidence

The pharmacy stored bags of assembled medicines safely in a designated area to the side 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 screens. Pharmacy team members used passwords and NHS smartcards to access people's medication records. They had access to a cordless telephone handset which allowed them to move out of earshot of the public area when discussing confidential information over the telephone.

Team members had access to a good range of reference resources through a digital subscription service. And they used the internet to obtain information to support them in answering some queries and when signposting people to other healthcare services. Team members used crown-stamped measuring cylinders when measuring liquid medicines and they used clean counting equipment for counting tablets and capsules. Equipment for providing consultation services was stored neatly in the consultation room. But some syringes within the anaphylaxis treatment kit had recently expired. The RP acted to dispose of these safely. A supply of other syringes was readily available within the kit. A discussion highlighted the need to ensure equipment and sundries kept in the consultation room formed part of the team's regular stock management checks. 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.