General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Well, 103 Hornsby Road, Earlsfield, GRANTHAM, Lincolnshire, NG31 7XD

Pharmacy reference: 1034256

Type of pharmacy: Community

Date of inspection: 23/11/2023

Pharmacy context

The pharmacy is on a housing estate in the Lincolnshire town of Grantham. Its main services include dispensing NHS prescriptions and selling over-the-counter medicines. The pharmacy offers a seasonal flu vaccination service, and it provides substance misuse services. 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 identifies and manages the risks associated with its services effectively. It keeps people's confidential information secure, and it generally keeps the records it must by law. Its team members respond to feedback appropriately. And they know how to recognise, and report concerns to help keep vulnerable people safe. They share learning following mistakes being brought to their attention. And they act to reduce the risk of making similar mistakes.

Inspector's evidence

The pharmacy had a range of standard operating procedures (SOPs) to support its safe and effective running. It held these electronically and reviewed them on a rolling two-year rota. Team members had completed learning associated with the SOPs. They were informed regularly of updates and training required and explained they completed the learning in their own time. The responsible pharmacist (RP) was a member of the wider relief team, it was their first time working at the pharmacy. They demonstrated their training records and were observed working well with the team members on duty.

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. But they explained some pharmacists worked to correct mistakes without taking the opportunity to provide feedback to the team member involved. This meant there was missed opportunities to share learning following a near miss. The RP explained how they would manage mistakes identified following the supply of a medicine to a person, known as dispensing incidents. Team members followed reporting processes after receiving feedback about both near misses and dispensing incidents. And they engaged in regular patient safety reviews designed to share learning following mistakes. The team provided examples of changes made to the layout of stock within the dispensary drawers to help reduce the risk of a picking error occurring.

The pharmacy advertised its complaints procedure. This notice was within a screened area to the side of the medicine counter. So, there was a chance people using the pharmacy would not directly see how they could provide feedback or raise a concern. Team members understood how to manage a concern, and the RP explained how they would provide details of the pharmacy's head office if a concern could not be resolved locally. All pharmacy team members completed mandatory learning about safeguarding vulnerable people. They had guidance to refer to if they came across a concern. And they knew where to look to obtain current contact information for local safeguarding teams. The pharmacy advertised its consultation room as a 'safe space' to people. A discussion during the inspection improved the team's knowledge of code words associated with safety initiatives designed to support people experiencing domestic violence in accessing this safe space.

The pharmacy stored personal identifiable information in staff-only areas of the premises. It displayed a privacy notice. The team disposed of confidential waste securely through a specialist waste contractor. The pharmacy had current indemnity insurance. The RP notice was updated as the inspection began to reflect the correct details of the RP on duty. The RP record was mostly completed as required. But there were two days in November 2023 where an entry had not been made by the RP on duty. A sample of other pharmacy records examined complied with legal and regulatory requirements. This included

records associated with controlled drugs (CDs), private prescriptions and unlicensed medicines. The pharmacy maintained running balances in the CD register and completed full balance checks of physical stock against the register regularly, in accordance with the pharmacy's SOPs. A random physical balance check of CDs conducted during the inspection complied with the running balance in the register.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy employs a small and effective team of people who work enthusiastically in their roles. Pharmacy team members complete regular learning to keep their knowledge and skills up to date. They work well together by engaging in regular conversations to support workload and risk management. And they understand how to raise concerns at work.

Inspector's evidence

On duty was the RP and two qualified dispensers, one of which was the pharmacy's team leader. The pharmacy had a part-time vacancy for a dispenser and a regular pharmacist vacancy had recently been appointed to. A company-employed delivery driver provided the medicine delivery service. Team members were up to date with their work. They explained that due to the size of the team there was a reliance on each other to cover leave and this was difficult at times. This meant staffing levels were reduced for the period of the leave which heightened pressure. The team was very vigilant with planning its workload. And team members strived to get ahead of managed workload ahead of taking leave. But they explained that this meant they did not always follow the company's operational guidance that supported its SOPs when completing tasks. For example, they deviated from the guidance when dispensing medicines as part of the hub and spoke arrangement.

Pharmacy team members completed regular e-learning relevant to their roles. They worked together well to manage workload and were observed working with the RP effectively. The RP felt able to apply their professional judgement when carrying out services. But team members felt there was some pressure on them to achieve targets and explained that performance against targets was monitored closely through regular recorded conversations. The team provided examples of how it promoted its services to people. For example, assembled bags of medicines were highlighted with details of the service a person was eligible to receive. Team members explained they tried to strike a balance during particularly busy periods by prioritising dispensing tasks to help reduce feedback about waiting times and to reduce the risk of making a mistake. The pharmacy team engaged in regular conversations about workload and risk management. It recorded learning points within its monthly patient safety report to help reduce risk. The pharmacy had a whistleblowing policy. Its team members understood how to raise and escalate a concern at work.

Principle 3 - Premises ✔ Standards met

Summary findings

Overall, the premises are clean, secure, and suitably maintained. They offer a professional environment for delivering healthcare services. People using the pharmacy can speak with a member of the pharmacy team in a private consultation space. But care is required to ensure conversations taking place inside the room are not overheard within the public area.

Inspector's evidence

The pharmacy was secure against unauthorised access. Overall, it was maintained well. There was one outstanding maintenance concern which the team had raised. Initial repair works had been completed following water entering the premises. But damage caused by the water required urgent attention. Team members had acted appropriately by quarantining this area and the equipment within it to prevent a health and safety issue. The superintendent pharmacist's team provided confirmation that this work was being carried out the day following the inspection. The pharmacy was clean and organised. Floor spaces were generally free from trip and fall hazards. But some boxes containing stock were held at floor level in a storeroom. Team members had access to appropriate hand washing facilities. Lighting was bright and heating and ventilation was sufficient.

The public area was fitted with wide aisles. A consultation room led off this area. The room was a good size, and it was professional in appearance. But team members reported some conversations taking place in the room could be overheard in the public area. The position of chairs in the public area, close to the room also increased the chance of a conversation in the room being overheard. A semi-private area to the side of the medicine counter was also provided. The dispensary was a suitable size for the level of activity taking place. Workflow was organised well with separate areas used to complete each stage of the dispensing process. A door leading from the back of the dispensary provided access to a stock room and to staff facilities.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's services are accessible for people. It obtains its medicines from licensed sources and stores them safely and securely. Its team members carry out regular checks to ensure medicines are safe to supply. And they provide information to people when supplying medicines, to help them take them safely.

Inspector's evidence

The pharmacy was accessed through a power-assisted door. Its team members set-up a metal ramp between the step and pavement each day to assist people with access. The pharmacy advertised its opening times and details of the pharmacy services it provided. There was a range of helpful information leaflets available for people to take. Pharmacy team members knew how to signpost people to another pharmacy or healthcare provider if they required a service or medicine which the pharmacy could not provide. They were observed providing information and support to people in a professional manner throughout the inspection.

The pharmacy protected its Pharmacy (P) medicines from self-selection. Its team members were vigilant in monitoring requests for over-the-counter medicines subject to misuse. Pharmacists had access to current patient group directions, service specifications and supportive information when providing the seasonal flu vaccination service. Team members were keen to reduce harm when providing the needle exchange service. Supply of needles was limited to an emergency pack when people did not exchange. This encouraged people to dispose of their used needles safely by returning them to the pharmacy. The pharmacy team understood the requirements of the valproate Pregnancy Prevention Programme (PPP). A team member discussed the recent legal changes about supplying valproate in its original packaging. The RP was knowledgeable about the requirements of the PPP and explained how they would counsel people when handing out higher-risk medicines. But these checks were not recorded on the patient medication record (PMR) to support continual care. Team members highlighted assembled bags of medicines to prompt additional checks when handing out cold-chain medicines and CDs. This prompted an additional check of the assembled medicine prior to it being handed out to a person.

The pharmacy used coloured baskets throughout the dispensing process. This kept medicines with the correct prescription form and helped inform workload priority. It kept prescriptions for medicines owing to people. Team members used the prescription throughout the dispensing process when the medicine was later supplied. The pharmacy maintained an audit trail of the medicines it delivered to people's homes. It used the company's offsite dispensing hub to help it manage its workload. This process involved the team securely transferring data from people's prescriptions to the dispensing hub. The hub then dispensed the prescription and sent the medicine back to the pharmacy to be collected by or delivered to people. The pharmacy kept a clear audit trail showing who had entered the data on the computer and which pharmacist had undertaken a data accuracy check and a clinical check of the prescription. Pharmacy team members demonstrated how they safely managed prescriptions when part was dispensed at the hub and part was dispensed in the pharmacy. They used barcode technology to track prescriptions through the entire dispensing process. And they dispensed any medicines required to complete these prescriptions once the medicines were received back from the hub. They explained this differed to the company's operational guidance which promoted completing local

dispensing tasks ahead of medicines being received back from the hub. The team matched all of the bags together and scanned them to the same storage location. This mitigated the risk of only supplying part of the prescription to people. The pharmacy completed a daily audit which involved checking the accuracy of its hub dispensing model.

The pharmacy had a schedule to support it in supplying medicines in multi-compartment compliance packs to people. Team members used individual profile sheets to record details of people's medicine regimens. The team had recently introduced 'event diaries' and attached these to people's records to record the changes made to people's medicine regimens. A sample of assembled compliance packs contained full dispensing audit trails and descriptions of the medicines inside them. 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 an orderly manner, within their original packaging. The pharmacy stored CDs neatly within secure cabinets. It stored medicines requiring refrigeration in two fridges. It monitored and recorded the operating temperature range of both fridges to ensure medicines were kept within the required temperature range. But team members did not always reset the thermometers to ensure the minimum and maximum temperature recorded referred only to the previous 24-hour period.

The team regularly undertook stock management tasks such as date checking. A date checking record provided evidence of recent checks and also indicated that priority was given to dispensary stock. A random check of medicines both in the dispensary and behind the medicine counter found no out-of-date medicines. Short-dated medicines were highlighted well. The pharmacy had appropriate medicine waste bins, sharps bins and CD denaturing kits available. It received details of drug alerts electronically and printed these. It acknowledged these by providing a clear audit trail of the checks completed and the action taken in response to each alert.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the necessary equipment for providing its services. It maintains its equipment to ensure it remains fit for purpose and safe to use. And its team members use the equipment appropriately.

Inspector's evidence

The pharmacy protected its computers from unauthorised access by using passwords and NHS smart cards. It stored bags of assembled medicines safely in a retrieval area at the back of the dispensary. Pharmacy team members used cordless telephone handsets when speaking to people over the telephone. This allowed them to move towards the back of the dispensary or into the staff-only area when speaking to people over the phone. Team members had access to reference resources and the internet. They could also seek support from their superintendent pharmacist's team by telephone.

The pharmacy team used a range of appropriate equipment to support it in delivering the pharmacy's services. For example, crown-stamped measuring cylinders for measuring liquid medicine with separate measures identified for use only with a higher-risk liquid medicine. Pharmacists providing the flu vaccination service had access to appropriate equipment to support them in providing this service. This included immediate access to medicines and equipment used to treat an anaphylactic reaction. The pharmacy's equipment was subject to periodic checks to ensure it remained safe to use. For example, electrical equipment had been safety tested in April 2022.

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.