General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Well, 6 Centre Point, Fairstead Estate, KING'S LYNN, Norfolk, PE30 4SR

Pharmacy reference: 1035268

Type of pharmacy: Community

Date of inspection: 29/09/2022

Pharmacy context

The pharmacy is on a housing estate on the outskirts of King's Lynn in Norfolk. Its main services include dispensing NHS prescriptions and selling over-the-counter medicines. It provides the seasonal flu vaccination service. And it offers a range of private vaccination services. The pharmacy supplies some medicines in multi-compartment compliance packs, designed to help people remember to take their medicines. It also supplies medicines to people living in a local care home. And it offers a medicine delivery service.

Overall inspection outcome

✔ **Standards met**

Required Action: None

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 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 appropriately. It keeps people's private information secure. And it advertises how members of the public can provide feedback about its services. The pharmacy generally keeps all records it must by law. Its team members have the knowledge and ability to recognise and raise concerns to help safeguard vulnerable people. Pharmacy team members behave openly and honestly by discussing their mistakes. And they act to reduce risk following mistakes they make during the dispensing process.

Inspector's evidence

The pharmacy had standard operating procedures (SOPs) to support its safe and effective running. These covered responsible pharmacist (RP) requirements, controlled drug (CD) management, dispensary processes and services. It held SOPs electronically and reviewed them on a rolling two-year rota. A sample of training records confirmed pharmacy team members had completed appropriate learning associated with the SOPs. All team members on duty were observed completing tasks in accordance with SOPs. A trainee team member, present for part of the inspection, explained clearly what tasks could not take place if the RP took absence from the pharmacy. The pharmacy had business contingency plans readily available for its team members to refer to. This ensured the team had access to appropriate support should it identify a situation that could affect the safe running of the pharmacy.

Pharmacy team members engaged in learning following mistakes made during the dispensing process. The team generally used a paper record to record details of near misses, where a dispensing mistake was made but was identified before the medicine was handed to a person. The RP demonstrated how details from this record were then transcribed to the pharmacy's electronic reporting system. The team also used this system to support it in reporting dispensing incidents, where a dispensing mistake happened and the medicine was handed to a person. And the system was accessible by the pharmacy's superintendent pharmacist's team. This supported the company in identifying trends and sharing learning points with teams. Pharmacy team members explained how learning relating to medicines which looked similar or sounded alike helped to inform stock placement on the dispensary shelves by separating these medicines. Pharmacy team members regularly discussed the mistakes they made during the dispensing process in weekly team meetings. But they had not taken the opportunity to complete formal patient safety reports since May 2022. A discussion highlighted the importance of maintaining engagement in the formal patient safety reporting function, designed to help share learning and reduce risk.

The pharmacy had a complaints procedure and this was advertised. Pharmacy team members recognised how they would manage feedback and understood how to escalate a concern when required. Pharmacy team members were observed treating people with respect and greeting many people by name when they visited the pharmacy. But they expressed that incidents of verbal abuse towards them had increased over the course of the pandemic. Many of these were prompted by issues outside of the team's direct control. For example, stock shortages within the supply chain. The pharmacy team understood how to report such incidents. But a notice asking people to treat team members with respect was covered by a retail stand. Pharmacy team members were aware of how to recognise and report a concern about a vulnerable adult or child. There was contact information and

safeguarding protocols available for team members to refer to. A prominent poster advertised contact details for a local support service for victims of domestic abuse. All team members had completed learning about safeguarding vulnerable people.

The pharmacy stored personal identifiable information in staff-only areas of the premises. It held confidential waste in designated areas of the dispensary. And this waste was transferred to locked units in the staff area of the premises whilst waiting for secure disposal from a regular shredding service. The pharmacy had up-to-date indemnity insurance. The RP notice displayed contained the correct details of the RP on duty. A sample of pharmacy records examined confirmed the pharmacy generally kept the records required by law in good order. There were some minor improvements identified in private prescription records. This was because dates were occasionally omitted from records within the register. The pharmacy maintained running balances in the CD register. And the team completed regular full balance checks of CD stock against the register, in accordance with SOPs. A random physical balance check of a CD conducted during the inspection complied with the running balance in the register.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough team members to manage its workload. And it reviews its staffing levels and skill mix as services change. Pharmacy team members receive feedback about their own performance. They engage in ongoing discussions to share ideas and learning. And they understand how to raise concerns at work.

Inspector's evidence

The pharmacy was initially short-staffed as the inspection began. One team member was on annual leave and another had been given a day off as the pharmacy was expecting support from a member of the local relief team. This support had been re-assigned to another pharmacy at short notice. The RP was the pharmacy manager and was supported by a qualified dispenser as the inspection began. During the early stages of the inspection a trainee dispenser from another pharmacy arrived to provide some support to the team. The trainee returned to their own pharmacy once a relief dispenser arrived to support the team for the remainder of the day. The pharmacy also employed a pharmacy technician and a trainee dispenser. A company-employed driver provided the pharmacy's medicine delivery service.

The pharmacy team was slightly behind with workload, this appeared to be caused by a number of factors including leave within the team and the pharmacy not receiving a stock order. The team was working hard to catch up and prioritised acute dispensing tasks. Workload associated with the supply of medicines in multi-compartment compliance packs and to the care home was up to date. And records associated with the supply of higher-risk medicines through the substance misuse service were completed to date. The pharmacy had a whistleblowing policy and its team members understood how to raise and escalate concerns at work. The pharmacy team had very recently been informed of some planned changes to its staffing structure. This would see a reduction in staffing hours following a recent review. This had affected morale in the team due to the ongoing cost of living crisis. A team member discussed feeling able to provide feedback about upcoming changes to staffing hours during a recent team meeting held with the pharmacy's area manager.

Pharmacy team members had access to ongoing learning to support them in their roles. The pharmacy technician had recently completed vaccination training to support the delivery of the flu vaccination service. The pharmacy could monitor the progress of e-learning and team members received prompts to complete this learning via email. Pharmacy team members engaged in a structured annual appraisal process. There was some focus on the achievement of targets related to pharmacy services and patient safety. The manager demonstrated an example of a recent 'tracker' for the pharmacy. This demonstrated the team were engaging in key safety processes, such as near miss recording, and in the delivery of services, such as flu vaccinations. The RP discussed how the trackers were used to prompt discussion in weekly team meetings. And the pharmacy displayed its progress towards targets on a board in the dispensary. Team members shared information through continual discussions, weekly team meetings and some structured patient safety briefings.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are appropriately maintained. They provide an adequate space for the delivery of healthcare services. People using the pharmacy can speak with a member of the pharmacy team in a private consultation room.

Inspector's evidence

The pharmacy was secure and appropriately maintained. Pharmacy team members had recently reported some maintenance concerns and these had been dealt with in a timely manner. The pharmacy was generally clean, but there was some paper debris on the floor of the dispensary. Some non-working areas such as the staff room and a small storage room were somewhat cluttered with boxes and equipment. The clutter did not pose a health and safety risk and the pharmacy kept all public spaces and working areas clear. Lighting was bright throughout the premises. Pharmacy team members had access to sinks equipped with antibacterial hand wash and paper towels. Hand sanitiser was available for use. An external incident on the day of inspection meant the pharmacy had no access to running water for a period of time. It received supplies of bottled water almost immediately to help it in keeping services running. The public area was open plan with a designated waiting area. The consultation room door was kept locked between use. The room was clean and professional in appearance. It offered a suitable space for holding private conversations.

A gate deterred unauthorised access beyond the medicine counter. The dispensary was on two levels, the ground-floor level was used predominantly by the pharmacist and provided good space for completing tasks associated with checking medicines. There was shelving available to hold baskets of assembled items waiting to be checked. This allowed pharmacists to manage their workload effectively. This level of the pharmacy also provided protected space for completing tasks associated with the supply of medicines in compliance packs. A single step provided access to the next level of the dispensary. This level provided space for labelling and assembling tasks. And the shelving across this level was used to store stock medicines. A fan in the dispensary helped provide extra ventilation in summer months. The pharmacy also had a portable air conditioning in its public area.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's services are readily accessible to people. It obtains its medicines from reputable sources. And it generally stores its medicines safely and securely. The pharmacy has procedures to support its team members in delivering its services. And team members mostly follow these procedures with care. They provide some information when dispensing medicines to support people in using them correctly.

Inspector's evidence

People accessed the pharmacy through a door at street level. There was ample free carparking available close to the pharmacy. The pharmacy's designated waiting area had seats available for people to sit down whilst waiting. And it had information leaflets available about the pharmacy's services. Pharmacy team members were aware of how to signpost a person to another pharmacy or healthcare provider if they required a service which the pharmacy could not provide.

The pharmacy protected Pharmacy (P) medicines from self-selection as it displayed them behind the medicine counter. And the RP was able to supervise the activity taking place in the public area from the dispensary. The pharmacy team identified higher-risk medicines during the dispensing process. This helped prompt additional counselling when handing out these medicines. The team did not routinely record the outcome of these interventions on people's medication records. But it did record interventions associated with the valproate Pregnancy Prevention Programme (PPP). The RP provided evidence of this and discussed the requirements of the PPP. And the pharmacy had patient cards and counselling materials available to support it in complying with these requirements. The pharmacy stored assembled CDs and cold chain medicines in clear bags. This prompted additional checks when handing out the medicine. The pharmacy had up-to-date patient group directions (PGDs) and the national protocol for the flu vaccination service available to support its team in delivering its vaccination services.

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 routinely signed the 'dispensed by' and 'checked by' boxes on medicine labels to form a dispensing audit trail. The pharmacy kept original prescriptions for medicines owing to people. Team members used the prescription throughout the dispensing process when the medicine was later supplied. The pharmacy kept a clear audit trail showing who had entered the prescription on the computer and which pharmacist had undertaken an accuracy check of this data and a clinical check of the prescription. Pharmacy team members could demonstrate how they managed prescriptions when part was dispensed at the hub and part was dispensed in the pharmacy. This included ensuring those locally dispensed were assembled and checked in good time. Team members used barcode technology and an electronic scanning device which tracked the prescription through the entire dispensing process. Data on the device included storage locations of the assembled medicines held in the pharmacy. This mitigated the risk of people only being supplied with part of their prescription. Team members reported a recent increase in the number of rejections from the hub caused by stock supply issues. They demonstrated how a prescription could be pulled back from the hub and dispensed locally if needed. The pharmacy's delivery driver also used the barcode technology to support the safe delivery of

medicines. This provided and audit trail of delivery and supported the team in answering any queries relating to the service.

The pharmacy made supplies of medicines to the care home in original boxes with medication administration records (MARs) provided. This supported the safe administration of medicines and the re-ordering of prescriptions. The pharmacy managed prescription queries with the care home via NHS secure email. This supported it in maintaining an audit trail of the communication it had with homes. Workload associated with the supply of medicines in multi-compartment compliance packs was generally well managed. The pharmacy used individual patient record sheets to record people's medication regimens. But changes to people's medication regimens were not always tracked with clear information to support the change. A sample of assembled compliance packs contained full dispensing audit trails. But the backing sheets were not physically attached to the compliance packs. This increased the risk of them becoming detached from the pack after being supplied to people. A discussion shared common methods for securing the backing sheets to the packs safely. 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. It generally stored medicines in an orderly manner, within their original packaging, on shelves. But some areas of the dispensary required organisation as some medicines had fallen into those stored next to them. The pharmacy stored CDs appropriately within a secure cabinet. Medicines inside were stored in an orderly manner. The pharmacy had two fridges used to store medicines. These were an appropriate size for the medicines they held. Fridge temperature records confirmed they were operating within the correct temperature range of two and eight degrees Celsius. The team regularly recorded the completion of date checking tasks. A random check of dispensary stock found no out-of-date medicines and short-dated medicines were highlighted. The team annotated liquid medicines with details of their shortened shelf-life once opened. The pharmacy had appropriate medicinal waste bins and CD denaturing kits available. It received and actioned medicine alerts electronically.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the required 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 in a way which protects people's privacy.

Inspector's evidence

The pharmacy had up-to-date written and electronic reference resources available. Written reference resources included the British National Formulary (BNF). Pharmacy team members had access to the internet and intranet. The pharmacy protected its computers from authorised access through the use of passwords and NHS smart cards. It stored bags of assembled medicines on shelving to the side of the medicine counter. Details on bag labels and prescription forms could not be read from the public area. Pharmacy team members used a cordless telephone handset when speaking to people over the telephone. This meant they could move out of earshot of the public area if the phone call required privacy.

The pharmacy team used crown-stamped measuring cylinders for measuring liquid medicines. Equipment for counting capsules and tablets was also available. There was separate equipment available for counting and measuring higher-risk medicines. This mitigated any risk of cross contamination when dispensing these medicines. Equipment used to support the delivery of pharmacy services was from reputable manufacturers. For example, the pharmacy's blood pressure monitor was on the list of monitors validated for use by the British and Irish Hypertension Society. The pharmacy maintained its equipment to help ensure it remained safe to use and fit for purpose. For example, electrical equipment was subject to regular portable appliance testing.

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.