General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Well, 113 Clipstone Road West, Forest Town, MANSFIELD, Nottinghamshire, NG19 0BT

Pharmacy reference: 1035537

Type of pharmacy: Community

Date of inspection: 11/07/2019

Pharmacy context

This pharmacy is on a busy road leading into an ex-mining town. The pharmacy sells over-the-counter medicines and it dispenses NHS and private prescriptions. It offers advice about the management of minor illnesses and long-term conditions. It supplies medicines in multi-compartmental compliance packs, designed to help people remember to take their medicines. And it delivers medicines 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	1.4	Good practice	The pharmacy responds well to feedback by using it to improve the safety and quality of its services.
2. Staff	Standards met	2.2	Good practice	The pharmacy has good systems in place for supporting the learning needs of its team members through continual training and structured appraisals.
		2.5	Good practice	The pharmacy encourages its team members to seek support and to provide feedback. And it uses this feedback to inform the safe management of its services.
3. Premises	Standards met	N/A	N/A	N/A
4. Services, including medicines management	Standards met	4.1	Good practice	The pharmacy works effectively to promote pharmacy led services. This means people can access treatment and advice quickly and it reduces the impact on other healthcare providers.
		4.2	Good practice	The pharmacy team show how effective planning strategies help to manage risks associated with its services.
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. It keeps people's private information secure. The pharmacy responds well to feedback by using it to improve the safety and quality of its services. Pharmacy team members act openly and honestly by sharing information when mistakes happen. And they engage in some shared learning processes to help reduce identified risks. Pharmacy team members respond appropriately to safeguarding concerns and act to protect the welfare of vulnerable people. The pharmacy generally keeps all records it must by law. But some gaps in these records occasionally result in incomplete audit trails.

Inspector's evidence

The pharmacy had a set of up to date standard operating procedures (SOPs). The superintendent pharmacist's team reviewed these on a rolling two-year cycle. Pharmacy team members accessed SOPs electronically. They explained that once they had read a SOP, they completed an assessment to test their understanding of it. Training records demonstrated confirmed that the team had read and understood the SOPs. A member of the team explained what tasks could and couldn't be completed if the responsible pharmacist (RP) took absence from the premises.

The dispensary environment was clean and clutter free. The pharmacy team demonstrated how they used workspace effectively to manage risks during the dispensing process. Separate areas of the dispensary were used for labelling, assembly and final accuracy checking. And high-risk dispensing activities were completed in a quiet area of the dispensary. Pharmacy team members were observed applying thorough checks of their work before handing it over to the pharmacist for the final accuracy check.

Pharmacy team members took ownership of their mistakes by discussing them with the pharmacist at the time they occurred. The team entered near-misses onto an electronic database (Datix). This provided both the pharmacy and the superintendent pharmacist's team with oversight of the mistakes being made. Much of the pharmacy's workload came through repeat prescription services and the multi-compartmental compliance pack service. This meant that the team could plan their workload and were less likely to make a mistake caused by the pressure of acute work. Near-miss records identified some details of mistakes. But they did not usually include a reflection of the contributory factors. A discussion took place about the advantages of recording contributory factors to help inform risk management processes in the pharmacy. The team did discuss their near-misses and were aware that the pharmacy manager completed a monthly patient safety report. But the pharmacy did not regularly print and display this report which meant that it was not readily accessible by the team. Pharmacy team members demonstrated actions taken to separate some 'look alike and sound alike' medicines following the receipt of information from the superintendent pharmacist's team.

The pharmacy had an incident reporting procedure in place. Reporting took place through Datix. The pharmacy team demonstrated actions taken to reduce risk following these types of mistakes. For example, the team had reviewed and adapted the process for attaching address labels to bags of assembled medicines waiting for delivery following an incident which had involved a bag label transferring to another package in error.

The pharmacy had a complaints procedure in place. And it provided details of how people could leave feedback or raise a concern about the pharmacy through a notice in the public area. A member of the team explained how she would manage a complaint and understood how to escalate concerns if required. Pharmacy team members provided examples of how they had worked with surgery teams to share learning and manage concerns. following a concern relating to an incorrect NHS fine notice received by a person. The pharmacy engaged people in feedback through an annual 'Community Pharmacy Patient Questionnaire' and it published the results of this survey for people using the pharmacy to see. The pharmacy team had discussed feedback from the latest questionnaire and had used it to improve signposting to the pharmacy's seated waiting area.

The pharmacy had up to date indemnity insurance arrangements in place. The RP notice contained the correct details of the RP on duty. Entries in the responsible pharmacist record complied with legal requirements. The sample of the controlled drug (CD) register examined was generally compliant with legal requirements. But the pharmacy did not always enter the address of the wholesaler when entering receipt of a CD. The pharmacy maintained running balances of CDs and these were checked weekly against physical stock. Methadone balances were often checked multiple times each week. A physical balance check of methylphenidate 5mg tablets complied with the balance in the register. The pharmacy maintained a CD destruction register for patient returned medicines. And the team entered returns in the register on the date of receipt. The pharmacy kept records for private prescriptions and emergency supplies within its Prescription Only Medicine register. Occasional dates were missing from some private prescription entries and emergency supplies were sometimes entered using medicine labels. This practice was discouraged, and a discussion took place about the advantages of ensuring all entries in the POM register were made in indelible ink. The pharmacy retained completed certificates of conformity for unlicensed medicines with full audit trails completed to show who unlicensed medicines had been supplied to.

The pharmacy displayed details of how it protected people's private information. Pharmacy team members had completed additional learning following the introduction of the General Data Protection Regulation (GDPR). They were knowledgeable about the requirements to protect people's confidentiality and demonstrated the pharmacy's systems for storing records containing personal identifiable information. The pharmacy had submitted its annual NHS information governance toolkit. The pharmacy had a contract in place with a reputable waste management company for the secure destruction of confidential waste.

The pharmacy had procedures and information relating to safeguarding vulnerable people in place. Pharmacy team members had completed e-learning on the subject and pharmacy professionals had completed level two learning. A pharmacy team member was very knowledgeable about safeguarding requirements, she had previously worked in a leadership role for safeguarding. And she explained actions the pharmacy had taken to support a vulnerable person. The delivery driver showed a good insight into safeguarding requirements. She explained how she shared concerns relating to people's health and wellbeing. And the pharmacy had acted to act on these concerns to help support people to remember to take their medicines.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough skilled and knowledgeable people to provide its services and it manages its workload effectively. It has good systems in place for supporting the learning needs of its team members through continual training and structured appraisals. The pharmacy encourages its team members to seek support and to provide feedback. And it uses this feedback to inform the safe management of its services. Pharmacy team members engage in ongoing conversations relating to risk management and safety. But they do not always record the key outcomes of these discussions to help measure the effectiveness of agreed actions.

Inspector's evidence

On duty at the time of the inspection was the RP (a locum pharmacist), two qualified dispensers, a delivery driver and a pharmacy technician. The regular pharmacist (pharmacy manager) was on leave. The pharmacy also employed another part-time dispenser who was due to leave the pharmacy shortly. The team explained they had agreed to take on the dispenser's hours between themselves after a review of staffing levels and skill mix. The pharmacy did have access to relief staff if required but had not needed to use the relief team in recent years.

The pharmacy team members appeared happy and were enthusiastic when discussing their roles. They reported engaging in monthly one-to-one conversations with the pharmacy manager as part of the pharmacy's structured appraisal process. The pharmacy planned its workload well. Within the week of inspection, the pharmacy had installed a new computer system and had commenced a hub and spoke service 'central fulfilment'. This had minimal impact on workload as the team had planned for the changes well. The pharmacy team members discussed the training and support they had received during the introduction of the new system and central fulfilment service. Team members also had access to ongoing learning relevant to their roles and the pharmacy provided time during working hours for its team to complete this learning. Learning included regular e-learning modules and reading newsletters and SOPs. The pharmacy team also engaged in shared learning on different topics. For example, managing high-risk medicines. A member of the team discussed how she used the knowledge gained from high-risk medicine training to inform conversations with people taking these medicines.

The pharmacy team was clearly focussed on delivering a good level of customer service to people using its services. People were greeted, often by name, as they approached the medicine counter and staff were friendly and engaged people in conversation about their health and wellbeing. Pharmacy team members were aware of targets in place. These were linked to services and sales. They explained the manager updated the team on progress towards these targets. And they identified how they contributed to targets by identifying people who may benefit from the pharmacy's services during the dispensing process. The RP on duty was seen to be well supported by the team and confirmed she could apply her professional judgement when undertaking services.

The pharmacy team shared information through daily informal discussions and a weekly team briefing. Pharmacy team members confirmed they were encouraged to participate in these discussions. But the pharmacy didn't always record details of these briefings to encourage reflection and review of the actions discussed. The pharmacy had a whistleblowing policy in place and it displayed details of its

confidential employee assistance line. Pharmacy team members regularly provided feedback and contributed ideas to encourage safe and effective working. For example, storage arrangements inside the pharmacy's CD cabinets had been improved following concerns from a member of the team about the potential difficulty in locating a medicine efficiently.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean and secure. It provides a professional environment for the delivery of its services. The pharmacy's consultation room is accessible to people wanting a private conversation with a member of the team. And the team promotes access to the room.

Inspector's evidence

The pharmacy was clean and secure. Work benches and floor spaces were clear of clutter. The pharmacy team reported maintenance and IT issues to its head office. There were no outstanding maintenance issues found during the inspection. Lighting was bright, and the pharmacy had air conditioning to help regulate temperature. Antibacterial soap and paper towels were available close to designated hand washing sinks.

The public area was small and open plan. It presented a professional image to those using the pharmacy's services. The pharmacy had a good size consultation room. The room was clutter free and clean. It was sign-posted and offered an appropriate space for holding confidential conversations with people. The RP was observed using the room with people accessing the pharmacy's services.

The dispensary was a good size for the level of activity taking place. High-risk dispensing tasks such as the assembly of multi-compartmental compliance packs took place in a separate section of the dispensary. This section offered a distraction free environment for people working in it. A small room to the side of the dispensary was used to hold assembled medicines waiting for delivery. Staff facilities were provided at the rear of the premises.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy promotes its services and makes them accessible to people. It engages well with people to encourage improvements to their health and wellbeing. The pharmacy works effectively to promote pharmacy led services. This means people can access treatment and advice quickly and it reduces the impact on other healthcare providers. The pharmacy has records and systems in place to make sure people get the right medicines at the right time. The pharmacy team show how effective planning strategies help to manage risks associated with its services. The pharmacy obtains its medicines from reputable sources. And it generally stores and manages them appropriately to help make sure they are safe to use. It has some systems in place to provide assurance that its medicines are fit for purpose.

Inspector's evidence

The pharmacy was accessed by steps through a push/pull door. A bell at the bottom of the steps alerted the team when somebody required assistance with access into the pharmacy. The pharmacy also had a hearing loop. The pharmacy's delivery service was promoted to people who could not physically access the pharmacy to collect their medication. Seating was provided for people wishing to wait for prescriptions or services. The pharmacy team members were knowledgeable about how to refer people to other pharmacies or health services, in the event they were not able to provide a service.

The pharmacy supported national health campaigns by promoting these to people using the pharmacy. It made good efforts to reach out to people through the services it provided. And it worked well with other healthcare organisations to maximise the benefits people received from its services. For example, the pharmacy provided an ear, nose and throat (ENT) triage service and a urinary tract infection treatment service. The regular pharmacist had undertaken extended learning to offer these services. And up-to-date and legally valid patient group directions (PGDs) were available to support the services. Records showed that interventions and treatment plans were clearly recorded, these included clear indication of the need to refer on to a GP when required. The pharmacy also supported people with access to medicines through a minor ailments service. They explained how the service helped to reduce the impact on GP services by encouraging people to visit the pharmacy for support in managing minor health concerns.

There was evidence of completion of practice-based audits. And pharmacy team members had a sound understanding of how to recognise and discuss high-risk medicines with people taking them. The pharmacy prominently highlighted prescriptions for high-risk medicines, including valproate. And a member of the team demonstrated how a notice at the pharmacy counter prompted discussion relating to the monitoring and side-effects of these medicines. Pharmacy team members had engaged in training on the subject and were clear when to refer on to the pharmacist. For example, if a person in the high-risk group presented with a prescription for valproate. The pharmacy recorded the outcome of monitoring checks on people's medication records. And it participated fully in the valproate pregnancy prevention programme (VPPP).

The team had completed training and competency tests prior to sending prescriptions to the company's hub as part of its central fulfilment service. The pharmacy had planned the integration of this new service well. Its team was sending a limited number of prescriptions which could be fully dispensed by

the hub in the first few weeks. They planned to increase this by sending more prescriptions and part prescriptions as they became familiar with the system. Pharmacy team members could demonstrate how prescription details were recorded and sent to the hub. The accuracy of the information and clinical check was completed by the branch pharmacist prior to prescriptions being sent. 'Post-hub' checks were also in place. This required the branch pharmacist physically checking the first 300 items dispensed by the hub to ensure the process was robust and safe. The pharmacy planned to send results of these checks to the hub. The pharmacy team had clearly marked a section of shelving in the dispensary for part-prescriptions when some of the medicines were dispensed locally and others by the hub. The team demonstrated how it used a tracking device throughout the process. This device provided information relating to the status of the prescription from it being entered on the system to the assembled items being physically handed-out to a person.

The pharmacy used a planner and communication diary to support workload associated with the multi-compartmental compliance pack service. Individual profile sheets were in place for each person on the service. A dispenser explained how changes to medicine regimens were checked with the surgery before being recorded on the profile sheets. A three-way checking process was in place between the prescription, profile sheet and backing sheet during the dispensing process. A sample of assembled packs contained full dispensing audit trails. The pharmacy provided descriptions of the medicines inside the packs, to help people identify them. But it did not routinely attach backing sheets to the packs. A discussion took place about the risks associated with not securely attaching backing sheets and common practice for attaching these in a safe way was shared. The pharmacy supplied patient information leaflets at the beginning of each four-week cycle of packs.

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 signed the 'dispensed by' and 'checked by' boxes on medicine labels to form a dispensing audit trail. The pharmacy team kept original prescriptions for medicines owing to people. The team used the prescription throughout the dispensing process when the medicine was later supplied. It maintained delivery audit trails for the prescription delivery service and people signed to confirm they had received their medicine. The pharmacy maintained an audit trail of people it ordered prescriptions for. And it kept details of what was ordered. This meant the team could manage queries and chase missing prescriptions prior to the person attending to collect their medicine.

The pharmacy sourced medicines from licensed wholesalers and specials manufacturers. Pharmacy team members demonstrated some awareness of the aims of the Falsified Medicines Directive (FMD). The pharmacy's clinical software programme had been upgraded and the team were aware this was in preparation for FMD. Pharmacy team members were aware the pharmacy would go live with FMD compliant processes following training and the implementation of the new upgraded software across all pharmacies.

The pharmacy stored Pharmacy (P) medicines behind the medicine counter. This meant the RP had supervision of sales taking place and was able to intervene if necessary. The pharmacy stored medicines in the dispensary in an organised manner. And medicines were generally stored within their original packaging. But a plain amber bottle with tablets inside was found secured to a box of quinine sulfate 200mg tablets. This was brought to the attention of the RP, who acted to dispose of the tablets. And the RP confirmed she would feedback the importance of storing medicines in fully labelled containers to the team. The team followed a date checking rota to help manage stock. And they had worked ahead of due checks as part of time-planning for the new clinical software programme and central fulfilment service. Short dated medicines were identified. The team annotated details of opening dates on bottles of liquid medicines. No out-of-date medicines were found during random checks of dispensary stock.

The pharmacy held CDs in secure cabinets. The cabinets were exceptionally organised. There was designated space for storing patient returns, and out-of-date CDs. Assembled CDs were held in clear bags with details of the prescription's expiry date annotated on the attached prescription. Pharmacy team members could explain the validity requirements of a CD prescription. The pharmacy's fridge was clean and stock inside was stored in an organised manner. Temperature records confirmed that the fridge was operating between two and eight degrees Celsius as required.

The pharmacy had medical waste bins and CD denaturing kits available to support the team in managing pharmaceutical waste. The pharmacy received drug alerts through its intranet. The pharmacy team printed and recorded checks of the alerts. And these were kept for reference purposes.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy team has access to all the equipment it needs for providing its services. It monitors this equipment to ensure it is safe to use and fit for purpose.

Inspector's evidence

The pharmacy had up-to-date written reference resources available. These included the British National Formulary (BNF) and BNF for Children. The company intranet and the internet provided the team with further information. Computers were password protected and computer monitors faced into the dispensary. All pharmacy team members had working NHS smart cards. The pharmacy team stored assembled bags of medicines in cupboards to the side of the medicine counter. These storage arrangements protected people's private information against unauthorised view. The pharmacy team members used cordless telephone handsets when speaking to people over the telephone. And they moved to the back of the dispensary, out of earshot of the public area when speaking on the telephone.

Clean, crown stamped measuring cylinders were in place. The pharmacy used separate measures for high-risk medicines such as methadone. The pharmacy had counting equipment for tablets and capsules. Staff washed this equipment between use. Pharmacy team members assembled medicines into single-use multi-compartmental compliance packs and gloves were accessible to staff assembling these packs. The pharmacy regularly monitored its equipment. For example, the blood pressure machine was annotated with a sticker confirming the date of its next routine monitoring check. And electrical equipment was subject to 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.