General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Collingham Pharmacy, High Street, Collingham, NEWARK, Nottinghamshire, NG23 7LB

Pharmacy reference: 1035579

Type of pharmacy: Community

Date of inspection: 15/03/2023

Pharmacy context

The pharmacy is situated alongside a medical centre in the village of Collingham in Nottinghamshire. It is co-located with the medical centre's dispensary. Its registered pharmacy services include dispensing NHS prescriptions, selling over-the-counter medicines and providing advice to people suffering from minor ailments. The pharmacy supplies some medicines in multi-compartment compliance packs, designed to help people remember to take their medicines.

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 uses the feedback it receives to inform the way it manages its services. And it proactively shares the steps it is taking to respond to common issues affecting pharmacies.
2. Staff	Standards met	2.4	Good practice	The pharmacy uses regular patient safety reviews to identify and address individual learning needs as well as shared learning opportunities. Pharmacy team members are enthusiastic and proactively engage in continual learning to inform the safe delivery of pharmacy services.
		2.5	Good practice	Pharmacy team members feel empowered to share their thoughts and ideas through regular team meetings. The pharmacy acts on these ideas to support the safe delivery of its services.
3. Premises	Standards met	3.2	Good practice	The pharmacy's consultation room is fitted out to a high standard and the team actively promote it to people using the pharmacy.
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 uses effective monitoring tools to support it in identifying and managing risks associated with its services. It keeps people's personal information secure, and it generally keeps the records required by law in good order. The pharmacy advertises how people can feedback about its services. It acts on feedback effectively by using it to inform the way it provides its services, and to promote common issues affecting pharmacies. Pharmacy team members work well to identify and share concerns about vulnerable people to help keep them safe from harm. They act openly and honestly by sharing information following the mistakes they make during the dispensing process.

Inspector's evidence

The pharmacy had a range of up-to-date standard operating procedures (SOPs) designed to support its safe and effective running. The SOPs covered responsible pharmacist (RP) requirements, controlled drug (CD) management, information governance processes and pharmacy services. Supportive information such as regulatory guidance was available within the SOP folders to support team members learning. The pharmacy kept a training record associated with the SOPs and this confirmed that its team members had read and understood those relevant to their job roles. Team members demonstrated a good understanding of their own roles, and when to refer to a pharmacist for support. And the team was observed following good processes to ensure workload between the dispensing doctors and registered pharmacy businesses stayed separate. This was necessary to support an effective workflow and stock control of both businesses.

A pharmacy team member explained how they would be asked to look at their work again to identify and correct a mistake made and found during the dispensing process, known as a near miss. The pharmacy kept a record of its near misses but reporting levels occasionally dropped during periods of heightened pressure. For example, near miss reporting had dropped significantly in December 2022. The pharmacy had a procedure for reporting mistakes identified after a medicine was supplied to a person, known as a dispensing incident. And team members followed this procedure. The superintendent pharmacist (SI) led a monthly clinical governance meeting. This meeting was an opportunity to review patterns in mistakes and highlight areas for improvement. The review also calculated mistake reporting rates. This had allowed the pharmacy to identify periods of low near miss reporting. And it had acted on this information through both personal and shared learning which had highlighted the importance of acting openly and honestly when a mistake occurred. A team member shared a recent example of an action taken to reduce risk following a trend in mistakes, this had involved separating different strengths of the same medicine on the dispensary shelves. Pharmacy team members had access to supportive information to assist them in identifying medicines at higher risk of being involved in a mistake. Some of this information had been displayed for several years but it remained relevant. For example, posters in the staff area of the pharmacy provided information about medicines that sounded similar and looked alike.

The pharmacy had a complaints procedure, and this was clearly advertised within its practice leaflet and on a notice close to the medicine counter. The pharmacy had acted on recent feedback following a health and safety inspection by creating specific holding areas for wholesaler totes containing stock

medicines. It also provided up-to-date and relevant information to people on a noticeboard in the public area about common issues facing community pharmacy teams. For example, medicine supply shortages. This helped to inform people of the steps the team was taking to manage these issues. A team member demonstrated a sound understanding of how they would respond to feedback from a member of the public. Pharmacy team members had completed learning associated with safeguarding vulnerable people. They had procedures and contact information available to them to support them in reporting any concerns. They medical centre had a designated safeguarding lead who was the first point of contact should a safeguarding matter arise. Pharmacy team members were aware of how to support a person requesting support through either the 'Ask for ANI' or 'Safe Space' safety initiatives, designed to support people suffering from domestic abuse. Team members shared information directly with the medical centre through its clinical record keeping system. A team member had acted calmly and professionally when faced with upsetting circumstances on a couple of occasions when delivering medicines to people's homes. And they had been offered support following these events.

Pharmacy team members completed training associated with protecting people's confidentiality. The pharmacy stored personal identifiable information in staff-only areas of the premises. It had a secure system for destroying confidential waste. The pharmacy had up-to-date indemnity insurance arrangements. The RP notice displayed the correct details of the RP on duty. The RP record was generally maintained in a accordance with requirements. But on some occasions RPs did not sign out of the record as required. The pharmacy mostly kept its private prescription register in accordance with legal requirements. This was held electronically; some entries did not reflect the correct details of the prescriber. The pharmacy kept records relating to the supply of unlicensed medicines in accordance with the requirements of the Medicines and Healthcare products Regulatory Agency. The pharmacy maintained its electronic CD register with running balances. It completed balance checks upon the receipt and supply of CDs. And it completed full checks of physical stock against balances recorded in the register monthly. A physical balance check completed during the inspection complied with the running balance recorded in the CD register. The pharmacy had a patient returned CD destruction record and it kept this up to date.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy employs a team of skilled and knowledgeable people to provide its services safely. It supports the learning and development needs of its team members effectively. Pharmacy team members demonstrate enthusiasm for their roles. They engage in regular team discussions centred around safety. Team members feel empowered to provide feedback. And the pharmacy uses their ideas to inform the way it delivers its services.

Inspector's evidence

The pharmacy employed two pharmacists, the SI worked full-time, and another pharmacist worked part-time alongside the SI two days a week. Locum pharmacists supported cover for leave. Three qualified dispensers, three trainee dispensers and a trainee medicine counter assistant also worked at the pharmacy and undertook tasks associated with the registered pharmacy business. There had been some changes to skill mix and staffing levels over the last few years. This situation was monitored, and the pharmacy was currently looking for a pharmacy technician to work in an accuracy checking technician role to support skill mix across the team. Some pharmacy team members worked additional hours to support cover for leave when required. The pharmacy owners had recognised ongoing challenges with recruitment and finding regular locum cover. There were no specific targets related to other pharmacy services. This allowed the team to focus its energy on providing essential NHS services safely and effectively.

Pharmacy team members engaged in regular learning associated with their role. Those in training roles were progressing through GPhC accredited courses relevant to their role. Learning was monitored and included core learning related to SOPs and learning associated with the services the pharmacy provided. The monthly patient safety review also identified personal learning which was fed back to individual team members. The pharmacy was closed between 13:00 and 14:00 on weekdays. Team members working hours included half an hour during this lunch break period. They used this time to complete some workload and learning. This meant people could engage in learning in an environment which was free from interruption. Team members also engaged in an annual appraisal to support their learning. And they felt able to feedback during the appraisal process. For example, by raising topics to support their learning and development needs.

Pharmacy team members communicated well with each other. They engaged in ongoing discussions to share learning between formal team meetings. For example, pointing out similar looking medicines when receiving stock of medicines to help reduce the risk of a picking error occurring. The pharmacy recorded the details of discussion points from its monthly clinical governance meetings. These meetings provided team members with opportunities to provide feedback and share ideas. For example, the team was trialling a new prescription retrieval system in response to feedback from the team. And it had also introduced a new way of holding split packs of medicines on the dispensary shelves to reduce the risk of information on the medicine box from being crossed through. The pharmacy had a whistleblowing policy, and its team members knew how to raise and escalate a concern at work.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is secure and maintained to a good standard. It offers a modern and professional environment for delivering its services. Pharmacy team members actively promote the use of the private consultation room. This allows people to have confidential discussions with a member of the team in a quiet and professional space.

Inspector's evidence

The pharmacy was modern and professional in appearance. Its team members understood how to report maintenance concerns. There were no outstanding concerns reported. The pharmacy was clean throughout. A sink in the lower dispensary provided access to water for reconstituting liquid medicines. The team had access to hand-washing facilities in the staff only area of the pharmacy. Hand sanitiser was provided to both staff and members of the public. The pharmacy had kept its infection control measures introduced during the initial stages of the coronavirus pandemic. For example, team members wore type II R face masks whilst working, the sanitising unit in the public area was touch free and a robust plastic screening was fitted at the medicine counter. Lighting was bright and air-conditioning was in working order.

The public area of the pharmacy consisted of wide-spaced aisles. This allowed people in wheelchairs and those with pushchairs easy access into and around the area. A secure door led from the public area to the staff area of the pharmacy. The pharmacy's consultation was appropriately soundproof and a chaperone notice on the door to the room informed people of their right to have a chaperone present during a consultation. The room was clean and fitted out to a notably high standard with clinical services in mind. For example, flooring was durable, and easy to maintain and clean. It was well advertised, and team members consistently promoted its use to people. The dispensary was split across two levels. Registered pharmacy activities took place in the upper dispensary. A couple of steps led down to the dispensing doctor's dispensary. To the right of this dispensary was an area used for administration tasks and the storage space for bags of assembled medicines waiting for collection and delivery. Staff kitchen and toilet facilities were also available within the premises.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy makes its services fully accessible to people. It works well with other healthcare professionals to share information and to ensure people receive timely support for their healthcare needs. And team members engage people in conversations about their health and their medicines. The pharmacy obtains its medicines from reputable sources. It stores them safely and securely and it uses effective processes to ensure they are safe to supply to people.

Inspector's evidence

People accessed through automatic doors from the large onsite carpark. There was a range of informative signs and information leaflets available to people, including an up-to-date practice leaflet. Team members were observed engaging with people about their health and wellbeing. And they answered a high volume of telephone calls throughout the inspection from people requiring advice. Pharmacy team members knew how to signpost people to other pharmacies or healthcare providers should they be unable to provide a service or supply a medicine. They identified urgent care needs and were able to support people overcome barriers with accessing pharmacy services and medicines. For example, the RP had engaged effectively with other local pharmacies in order to source stock of a medicine for a person with specific needs. The RP shared examples of positive outcomes for people following them accessing the NHS Hypertension Case-Findings Service. These examples included urgent interventions and referrals to a GP that had resulted in people commencing treatment for previously undiagnosed hypertension. Pharmacists had access to supportive information, including up-to-date Patient Group Directions (PGDs) to support the delivery of pharmacy services. The RP was in the process of completing learning associated with a recently updated PGD prior to signing it.

People registered at the medical centre provided written consent for the pharmacy team to access their medical records to support their care needs. The team used this facility well to support it in delivering its services. For example, it sent tasks directly to prescribers or the duty doctor when queries arose during the dispensing process. This provided an audit trail of the communication between prescribers and the pharmacy team. The RP provided examples of how this supported the timely supply of medicines and informed counselling needs. The team accessed medical records to support in answering queries from people or to confirm information during a consultation with a person. And to check monitoring records associated with the safe supply of some medicines. But the pharmacy did not identify these medicines to prompt additional counselling during the handout process. It identified other higher-risk medicines such as CDs and cold chain medicines to support additional checks during the handout process. The pharmacy engaged in audits related to the supply of higher-risk medicines. Its recent valproate audit had confirmed that it did not dispense valproate to people within the at-risk group. The RP was familiar with the requirement of the valproate Pregnancy Prevention Programme should this change. The pharmacy protected Pharmacy (P) medicines from self-selection as it displayed them behind the medicine counter. And the RP was able to supervise activity at the medicine counter from the dispensary. Pharmacy team members were aware of over-the-counter medicines liable to abuse, misuse and overuse. And they referred repeat or unusual requests directly to the RP.

Pharmacy team members signed the ‘dispensed by’ and ‘checked by’ boxes on medicine labels to provide an audit trail of their role within the dispensing process. They used coloured baskets when dispensing medicines to separate individual people’s prescriptions to avoid items being mixed up. The

pharmacy retained prescriptions for owed medicines, and team members dispensed from the prescription when later supplying the owed medicine. There was an audit trail to support the delivery of medicines to people. This helped the pharmacy team to answer any queries it received about the service. The trainee medicine counter assistant generally undertook tasks associated with this service and they explained how they fed information back to the RP and medical centre to support people's ongoing care needs.

The pharmacy had effective communication audit trails with the medical centre to support it in managing the supply of medicines to people residing in care homes. But it generally managed queries with the homes directly via telephone, rather than by secure email. The pharmacy supplied medicines in original packs with patient information leaflets provided. It supplied most care homes with Medication Administration Record (MAR) sheets or electronic MARs to support carers in administering medicines to people. The pharmacy dispensed some acute medicines only for people residing in one care home. It had received feedback from this home to state MAR sheets were not needed, and as such it did not supply them. The pharmacy kept paper records to support it in managing the supply of medicines in multi-compartment compliance packs. These records included changes made to people's medication regimens over time. An audit trail of the changes was available electronically. A sample of assembled compliance packs contained full dispensing audit trails and descriptions of each medicine inside the packs. But the pharmacy didn't routinely supply patient information leaflets at the beginning of each cycle of packs. This meant people may on occasion have limited information to support them in taking their medicine safely.

The pharmacy sourced medicines from licensed wholesalers and specials manufacturers. It stored medicines in an orderly manner, generally within their original packaging. Medicines not stored within their original packaging were stored in boxes and bottles with clear details of the medicine stored inside, including batch number and expiry date of the medicine. The pharmacy stored its medicines that were subject to safe custody appropriately within a secure cabinet. Stock and assembled medicines inside were held in an orderly manner. But the cabinet was nearing its storage capacity. The pharmacy's fridge was a suitable size for stock held. And fridge temperature records confirmed it was running within the correct temperature range of two and eight degrees Celsius. Team members recorded the date checking tasks they completed. And they identified short-dated medicines by using stickers to identify them. A random check of dispensary stock found no out-of-date medicines. And the team annotated liquid medicines with details of their shortened shelf-life once opened. The pharmacy had appropriate medicine waste receptacles, sharps bins and CD denaturing kits available. It encouraged people to return their unwanted medicines to the pharmacy. And it advertised details of manufacturer's recycling schemes, aimed at recycling plastic devices. It had a clear process for managing safety alerts about medicines. The team had actioned a very recent alert related to the UK withdrawal of pholcodine containing products in a timely manner.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has appropriate equipment and facilities 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

Pharmacy team members had access to a range of up-to-date paper-based and electronic reference resources. They used NHS smartcards and passwords when accessing people's medication records. The layout of the premises protected information on computer monitors from unauthorised view. Pharmacy team members used discretion when handling information via the telephone. They had recently requested a change to cordless telephone handsets to support them in managing telephone queries. The pharmacy stored bags of assembled medicines on designated shelving within the staff-only area of the pharmacy. This meant details on bag labels and prescription forms could not be read from the public area.

The pharmacy had a range of clean crown stamped glass measures for measuring liquid medicines. It had appropriate equipment for counting tablets and capsules, including a separate counting triangle for use when dispensing cytotoxic medicines. The pharmacy maintained its equipment well with regular checks to ensure it remained in good working order. For example, electrical equipment was subject to ongoing safety checks. And the blood pressure machine in its consultation room was calibrated at scheduled intervals.

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.