General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Well, 47 Sherwood Avenue, NEWARK, Nottinghamshire, NG24 1QH

Pharmacy reference: 1035586

Type of pharmacy: Community

Date of inspection: 18/02/2020

Pharmacy context

This is a community pharmacy a short walk from the town centre of Newark-on-Trent, a market town in Nottinghamshire. The pharmacy sells over-the-counter medicines and dispenses NHS and private prescriptions. It offers advice on the management of minor illnesses and long-term conditions. It supplies medicines in multi-compartment compliance packs, designed to help people remember to take their medicines. It also supplies medicines to a local care home. And it provides 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. It keeps people's private information secure. And it keeps its records required by law up to date. The pharmacy advertises how people can feedback about its services. Pharmacy team members share information when mistakes happen. And they make changes to their practice to improve patient safety. They understand how to recognise, and report concerns to help protect the health and wellbeing of vulnerable people.

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. And completed learning through watching videos and completing assessments to confirm their understanding of each SOP. The manager demonstrated training records. Training records for team members on duty were generally up to date. There was a need for some team members on long-term leave from the pharmacy to complete some learning associated with SOPs when returning to work. Dispensary team members were observed following dispensing SOPs during the inspection. And a trainee team member discussed her role. And provided details of the tasks she could and could not complete if the responsible pharmacist (RP) took absence from the pharmacy.

Pharmacy team members managed space in the dispensary well. There were separate workflows for acute prescriptions, managed prescriptions and for tasks associated with the multi-compartment compliance pack service and care home service. And the RP most often completed clinical checks of prescriptions waiting to be sent to the off-site dispensing hub on a computer at the back of the dispensary. This reduced the risk of interruption when completing these checks.

The pharmacy had a near-miss error reporting procedure. Pharmacy team members explained they had recently improved as a team by recording more near misses formally through the company's electronic reporting tool, 'Datix'. And records examined confirmed near miss reporting rates had been considerably low some months when compared to the number of items the pharmacy dispensed. A discussion took place about the importance of utilising reporting tools to help identify and manage risk throughout the dispensing process. And reporting rates for January 2020 were demonstrated and confirmed the team were engaging well in formal reporting processes. Pharmacy team members demonstrated some improvements they had applied following monthly patient safety reviews. For example, team members had dispensed directly from wholesaler totes on occasion. The team had recognised how this practice could increase risk during the dispensing process. And efforts had been made to restructure workflow and ensure the pharmacy order was put away in a timely manner.

The pharmacy reported dispensing incidents through Datix. And team members were involved in follow-up discussions and learning following an incident. Incident reports were available for inspection and contained details of actions taken to reduce risk following an incident. For example, the need to apply additional checks when dispensing medicines with more than one formulation available for selection. Details of incidents were included in monthly patient safety reviews. Team members explained the manager led these reviews and team members could contribute to them. They also provided examples of how wider learning following newsletters from the superintendent pharmacist's team contributed to safety management in the pharmacy. For example, identifying 'look-alike and

sound-alike' medicines on the dispensary shelves. And placing warning stickers to help prompt additional checks when selecting these medicines.

The pharmacy had a complaints procedure in place. It advertised how people could provide feedback or raise a concern about the pharmacy in its practice leaflet. And within a notice which was displayed in the public area of the pharmacy. A member of the team explained how she would manage a concern and escalate it on to the pharmacist or manager if required. And the team member was aware of how to escalate people's concerns to the pharmacy's regional manager or head office team if required. The pharmacy also engaged people in feedback through an annual 'Community Pharmacy Patient Questionnaire'. And it published these results for people using the pharmacy to see.

The pharmacy had up-to-date indemnity insurance arrangements in place. The RP notice displayed reflected the correct details of the RP on duty. The sample of the RP record examined was completed in accordance with legal requirements. Entries in the pharmacy's prescription only medicine (POM) register generally complied with legal requirements. But one entry provided details of a 'signed order'. The physical copy of the signed order did not contain details of the purpose for which the medicine was to be used. And the pharmacy did not have a Wholesale Distribution Authorisation for Human use (WDA(H)) to support this activity. Supply of medicines in this way was not seen to be frequent. Records relating to the supply of unlicensed medicines were made in accordance with the requirements of the Medicine & Healthcare products Regulatory Agency (MHRA). The pharmacy maintained running balances of controlled drugs (CDs) within its CD register. And it generally completed full balance checks against physical stock monthly. Physical balance checks of Medikinet 5mg tablets and dexamfetamine sulfate 5mg tablets complied with the running balances in the register. Entries in the register generally complied with legal requirements. But the pharmacy did not always record the address of the wholesaler when entering the receipt of a CD into the register. The pharmacy kept a patient returned CD register. And pharmacy team members wrote returns into the register on the date of receipt.

The pharmacy displayed a privacy notice. And pharmacy team members had completed learning associated with the procedures in place for managing confidential information. The pharmacy had submitted its annual NHS Data Security and Protection (DSP) Toolkit as required. It stored all personal identifiable information in staff only areas of the pharmacy. Pharmacy team members transferred confidential waste to 'Shred-it' bins. And the waste was collected by the waste management contractor for secure disposal at periodic intervals.

The pharmacy had procedures and information relating to safeguarding vulnerable adults and children. And contact information for local safeguarding agencies was available to the team. The pharmacy displayed a chaperone notice to people. All pharmacy team members had completed safeguarding e-learning. The RP had completed level two safeguarding learning through the Centre for Pharmacy Postgraduate Education (CPPE). A pharmacy team member explained how she would recognise and report a safeguarding concern to the RP. The RP discussed reporting requirements. And the pharmacy's delivery driver provided several examples of occasions where he had been required to report concerns relating to the safety and wellbeing of a person.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough skilled and knowledgeable people working to provide its services and to manage its workload effectively. The pharmacy supports its team members in continual learning relevant to their role. And it engages its team members in regular learning and performance reviews. It promotes ways in which its team members can provide feedback. Pharmacy team members engage in regular conversations about managing their workload and patient safety.

Inspector's evidence

On duty at the time of the inspection was the RP (a company employed relief pharmacist), the pharmacy manager (a qualified dispenser), another qualified dispenser and a trainee dispenser. Another trainee dispenser was on annual leave. And two other dispensers were on planned long-term leave. An increased turnover of staff was reported within the last few years. This had settled down following the relocation of staff from another pharmacy in a local town which had closed in 2019. A company employed driver provided the pharmacy's prescription collection and delivery service.

Team members expressed some worries about staffing levels during the inspection. This was due to an upcoming change which would see the pharmacy losing some 96 hours of staff cover across the working week. But the pharmacy team had been managing workload with two team members on long term leave for some months. And during this time had also been working without a regular pharmacist. The team had also begun using the company's offsite dispensing facility in late 2019. The pharmacy manager was due to leave the pharmacy in around a months' time. A new regular pharmacist had started the day prior to inspection.

Team members reported some continual learning through e-learning modules and reading SOPs and newsletters. The trainee dispenser on duty was enrolled on an accredited training course. But did not receive protected learning time at work to support her in completing this training. The trainee confirmed she was supported in her role by her colleagues and relief pharmacists. Team members did receive a formal appraisal at work. And a dispenser explained how the opportunity for progressing her role had been discussed at her last appraisal. Action had been taken since the appraisal to commence the enrolment process for the pharmacy technician training programme. Members of the team who had transferred from the pharmacy which had closed had received a set-up appraisal with the manager.

The pharmacy had some targets associated with the delivery of services. And the RP was positive when discussing some of the beneficial outcomes people received from taking part in services such as Medicines Use Reviews (MURs) Pharmacy team members supported pharmacists by identifying people who were eligible for a service during the dispensing process.

Pharmacy team members communicated through informal team conversations about workload and priorities during the working day. And a structured team briefing was held monthly as part of the patient safety review process. Team members confirmed they could provide feedback during these discussions. Notes relating to the safety review template were available electronically. But these were not routinely accessed by team members. This meant members of the team not on duty at the time a

meeting took place could miss some shared learning opportunities. The pharmacy had a whistleblowing policy in place. And pharmacy team members confirmed they could provide feedback and were aware of how to escalate a concern should they need to.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean and secure. It offers a suitable environment for delivering healthcare services. People using the pharmacy can speak with a member of the pharmacy team in confidence in a private consultation room.

Inspector's evidence

The pharmacy was reasonably well maintained and it was secure. The first floor of the premises had benefited from a refit within the last year. But there was an recent maintenance concern noted. This was thought to be caused by a leak within the refitted part of the premises. The concern was not causing any health and safety issues and it had been reported. Pharmacy team members confirmed any maintenance issues were reported to a dedicated support desk. And team members explained these were managed by priority. The pharmacy was clean. Floor spaces and workbenches were free from clutter. Antibacterial handwash and towels were available at designated handwashing sinks. The pharmacy had suitable heating and ventilation arrangements. Lighting throughout the premises was bright.

The public area was accessible to people using wheelchairs and pushchairs. There was a clearly sign-posted consultation room. The room was a sufficient size and it was professional in appearance. Pharmacy team members secured the room against unauthorised access between use. It was observed being used by the RP to deliver a Medicines Use review (MUR) during the inspection. The dispensary was a sufficient size for the level of activity undertaken. There was a room to the side of the dispensary utilised for some tasks associated with the multi-compartment compliance pack and care home services.

Off the back of the dispensary was staff facilities and a stairwell leading to the first floor of the premises. The main room of the first floor was open plan. It was used for storing archived records and dispensary sundries. Another room off this area contained old medicine waste bins. The manager reported that these were empty. Some bags of what appeared to be assembled medicines were held next to the bins. The room was dark and there was a deep step down into it. The manager explained team members had not entered this room since the refit of the first-floor as they were unsure how safe the area was. A discussion took place about the risks of not clearly indicating through signage that the room should not be entered and the need to review what was stored in the room. And dispose of any medicines stored in the room safely if required.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy promotes its services and it ensures its services are accessible to people. It obtains its medicines from reputable sources. And it keeps its medicines safe and secure. The pharmacy has procedures to support its team members in delivering its services. And team members generally follow these procedures with care. They provide information to people when dispensing medicines to support people in taking their medication safely.

Inspector's evidence

The pharmacy was accessed through a door from street level. It advertised details of its opening times and services in professional looking window displays. Further information relating to its services was promoted through leaflets available in the public area of the pharmacy. Pharmacy team members discussed how they would signpost a person to another pharmacy or healthcare provider if they were unable to provide a service.

Pharmacy team members highlighted some bags of assembled items waiting for collection with stickers. The stickers prompted team members to promote services such as MURs and New Medicines Service (NMS). Some 'pharmacist' stickers prompted referral to the RP for additional counselling. For example, assembled bags containing high-risk medicines such as warfarin, methotrexate and lithium. The RP explained verbal counselling would be provided to people on high-risk medicines. But details of these conversations and any associated monitoring checks were not routinely recorded on people's medication records. The pharmacy had the tools required to comply with the valproate pregnancy prevention programme (PPP). And pharmacy team members explained how they had identified people in the high-risk group during a recent NHS Pharmacy Quality Scheme (PQS) audit. The requirement to issue a PPP warning card to people in the high-risk group every time valproate was dispensed was discussed.

The pharmacy used colour coded 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. And it used the prescription throughout the dispensing process when the medicine was later supplied. The pharmacy kept an audit trail for its delivery service. And people were asked to sign for receipt of their medicines through the service. It also kept an audit trail of prescriptions it ordered through its managed repeat prescription service. This meant team members could chase a missing prescription or raise a query with the surgery ahead of the person collecting their medicine.

Pharmacy team members demonstrated the processes they followed when preparing prescriptions for offsite dispensing. They had received some training through e-learning and SOPs to support them in managing the service. A pharmacy team member entered data into the Patient Medication Record (PMR) system ahead of the RP logging onto the system and completing accuracy checks of this data and a clinical check of the prescription. The RP was responsible for submitting the data to the hub. The hub was utilised for the managed repeat service as team members were aware when people using this service were due to collect their medicines. Some prescriptions were assembled in part at the hub and

in part at the pharmacy. Pharmacy team members demonstrated how they managed these prescriptions. And they used a handheld scanning device to store the location of each part of the prescription within the prescription retrieval system. This mitigated the risk of a person only being supplied with part of their prescription. Pharmacy team members could demonstrate how people wishing to have their prescriptions dispensed locally at the pharmacy could withdraw consent for this service. SOPs associated with the hub and spoke model of dispensing included the need to complete a daily audit. This involved an accuracy check of one complete hub assembled prescription, one part-hub and part-locally assembled prescription and one locally assembled prescription. Only four days of checks had been recorded since mid-December 2019. The RP immediately responded when discussing the rationale behind these checks by completing the daily check during the inspection. And team members acknowledged they needed to support pharmacists in ensuring these checks were completed each day moving forward.

The pharmacy organised its workload associated with the multi-compartment compliance pack service by using a workload tracker. This allowed all team members to see what stage a prescription was at. A team member explained how changes to medicine regimens were checked with GP surgeries. But the pharmacy did not always record details of these checks on people's individual profile sheets. It had a 'hospital' folder and people's profile sheets were moved to this folder when the pharmacy was notified of a person being admitted to hospital. This helped prompt additional checks associated with changes to medication regimens when the person came out of hospital. A sample of assembled packs contained full dispensing audit trails and start dates of individual packs. The pharmacy provided descriptions of the medicines inside the pack to help people identify them. It supplied patient information leaflets at the beginning of each four-week cycle of packs.

The supply of medicines to the care home was also through multi-compartment compliance packs. A tracker was in place to support this service. Queries associated with missing prescriptions or changes to medicine regimens were queried with the care home. But these queries were not recorded formally. This meant it could be more difficult for the pharmacy team to answer questions associated with the outcome of a query, should one arise. A pharmacy team member demonstrated how medication administration record (MAR) sheets were provided alongside packs to the home. The pharmacy received interim prescriptions for people in the home through the Electronic Prescription Service (EPS). And it supplied MARs when dispensing interim medicines.

The pharmacy sourced medicines from licensed wholesalers and specials manufacturers. Pharmacy team members could recall some information being fed down to them about the requirements of the Falsified Medicine Directive (FMD). And they had completed some e-learning on the subject. But team members were not aware of any date for local implementation of FMD processes.

The pharmacy held CDs in secure cabinets. Medicine storage inside the cabinets was orderly. Patient returned CDs and out-of-date CDs were segregated from stock. There was a need for the pharmacy's authorised witness to visit to witness the destruction of some out-of-date medicines. The pharmacy held assembled CDs in clear bags. And the RP appropriately checked details of the assembled medicine against the prescription prior to supply. One assembled CD seen in the cabinet had a prescription attached which had been issued more than 28 days ago. This was brought to the immediate attention of the RP who took appropriate action to manage the situation. The pharmacy stored its cold chain medicines across three medical fridges. It used clear bags to store assembled medicines. This prompted additional checks prior to hand out. The pharmacy team monitored fridge temperatures. And records examined confirmed cold chain medicines were stored within the required temperature range of two and eight degrees Celsius.

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. It stored medicines in the dispensary in an organised manner and within their original packaging. The pharmacy team followed an electronic date checking rota to help manage stock and it recorded details of the date checks it completed. Some checks had been missed in late 2019. And team members explained this was due to the pharmacy having a new computer software programme installed. And beginning offsite dispensing processes. The team members had managed the situation by ensuring they returned to scheduled checks. And short-dated medicines were highlighted prominently on the dispensary shelves. Liquid medicines were annotated with details of their opening date. No out-of-date medicines were found during checks of dispensary stock.

The pharmacy managed its drug alerts electronically. The manager demonstrated how an audit trail was completed following receipt and checks of alerts. Medical waste bins, sharps bins and CD denaturing kits were available to support the team in managing pharmaceutical waste.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs for providing its services. It monitors its equipment to help provide assurance that it is in safe working order. And pharmacy team members manage and use equipment in a way which protects people's confidentiality.

Inspector's evidence

Pharmacy team members had access to up-to-date written reference resources. These included the British National Formulary (BNF) and BNF for Children. Internet access and intranet access provided further reference resources. The pharmacy had crown stamped measuring cylinders for measuring liquid medicines. These included separate measures for use solely with methadone. Counting equipment for tablets and capsules was available. The pharmacy held some equipment to support the delivery of its services in its consultation room. For example, a blood pressure machine was available. The machine was used for screening purposes only. And it was regularly checked to ensure it was in working order. The next check was seen to be due in March 2020.

Computers were password protected and faced into the dispensary. This prevented unauthorised view of information on computer screens. Pharmacy team members had working NHS smart cards. The pharmacy stored assembled bags of medicines waiting for collection to the side of the dispensary. Personal information on bag labels and prescriptions could not be seen from the public area. The pharmacy had cordless telephone handsets. These allowed its team members to move to the out of ear shot of the public area when discussing private information with people on the phone.

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.