General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Brinsley Pharmacy, 1 Brynsmoor Road, Brinsley, NOTTINGHAM, Nottinghamshire, NG16 5DD

Pharmacy reference: 1035605

Type of pharmacy: Community

Date of inspection: 18/07/2024

Pharmacy context

The pharmacy is in the Nottinghamshire village of Brinsley. Its main services include dispensing NHS prescriptions, selling over-the-counter medicines and providing advice to people. It offers people the option to collect their medicines through an automated collection point located to the side of the premises. The pharmacy provides a range of NHS consultation services including the NHS blood pressure check service, NHS Pharmacy First Service and seasonal vaccinations, including COVID-19 vaccinations. The pharmacy also provides a range of private consultation services including an ear care service and travel health vaccinations. It supplies some medicines in multi-compartment compliance packs, designed to help people remember to take their medicines. And it delivers medicines to people's homes and to people living in care homes.

Overall inspection outcome

Standards not all met

Required Action: Improvement Action Plan

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 not all met	1.3	Standard not met	The pharmacy does not support team members to fully understand their roles and responsibilities and what tasks they can and can't complete without a responsible pharmacist (RP) signed in. This blurs some lines of accountability within the pharmacy.
		1.6	Standard not met	The pharmacy does not keep appropriate records for all the private prescriptions it dispenses. It does not have effective processes to ensure its RP record is an accurate reflection of when a RP is on duty, or to ensure entries in the RP record are made personally by the RP. The pharmacy does not always make timely records when it receives and destroys some higher-risk patient-returned medicines.
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 not all met	4.3	Standard not met	The pharmacy does not have effective monitoring processes to ensure its refrigerators are storing medicines at the correct temperatures. It has not appropriately considered this monitoring requirement when assessing the risks of providing its vaccination services. The pharmacy does not always store higher-risk medicines requiring secure storage correctly. And its current processes do not ensure a pharmacist has direct supervision over these medicines.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance **Standards not all met**

Summary findings

The pharmacy does not manage all the risks for the services it provides as its team members do not demonstrate a clear understanding of their roles and responsibilities. They are not aware of the tasks they can and cannot perform without a responsible pharmacist signed in. The pharmacy does not keep all of its records as required by law. Pharmacy team members keep people's confidential information secure. And they have the knowledge they need to help protect vulnerable people. They act openly and honestly by discussing their mistakes. And they understand how to respond to feedback they receive about the pharmacy and its services.

Inspector's evidence

The pharmacy had standard operating procedures (SOPs) to support its safe and effective running. The latest version of the SOPs had been implemented by the superintendent pharmacist (SI) in August 2023. But it did not always update these when there was a change in the way the pharmacy provided a service. For example, it was using the functions of its PMR system to support a series of checks throughout the dispensing process. This required the RP to clinically check prescriptions prior to releasing them for labelling and assembly. The team then used barcode technology to complete checks during the assembly process and the final accuracy check of the medicine. The pharmacy's SOPs did not reflect this current process.

Team members had not signed all of the SOPs relevant to their role. And they did not always work in accordance with the SOPs. For example, on the day of inspection the SI was late arriving to work. The pharmacy was open and operational activity had commenced without the SI or any other pharmacist establishing the RP role. This had included team members accepting a delivery from a wholesaler, including the receipt of controlled drugs (CDs) without a RP present. Team members had logged onto the patient medication record (PMR) system to label a prescription, in doing they had made an entry into the RP record stating the RP had commenced their role at 09.01 despite the RP not arriving at the pharmacy until 09.18. Team members appeared unaware that they had completed the record or that the RP was required to make this entry personally. The SI explained this was a flaw in the RP record as the PMR required team members to select the pharmacist on duty before commencing labelling tasks. This showed a lack of understanding of the need to have a RP physically signed in before labelling activity could take place. Pharmacy team members were not aware of the difference between an RP not being signed in and an RP taking absence. They explained they would not handout any assembled medicines or sell a pharmacy (P) medicine if there was no RP signed in. But they would undertake tasks such as label and assemble a medicine and sell general sales list (GSL) medicines, both of these tasks required an RP to be signed in.

The pharmacy provided an extensive range of services including NHS and private consultation services. It had risk assessments and procedures to support the delivery of these services. The SI was a pharmacist independent prescriber (PIP). They had recently started to prescribe vaccinations during travel health consultations. They had introduced a SOP which identified the risks associated with providing a private prescribing service. Prior to providing the service they had engaged in learning and had assured themselves they had the required knowledge to prescribe these medicines safely. They had

delivered the service using a patient group direction (PGD) model for some time prior to moving to a PIP-led model.

The pharmacy had a procedure for managing mistakes made and identified during the dispensing process, known as near misses. Pharmacy team members reviewed and corrected their own mistakes, and they engaged in consistent reporting of these types of mistakes. The team had historically reviewed these reports to help identify trends in mistakes, but they had not completed any recent reviews. Team members used the PMR tools to help reduce the risk of making mistakes such as picking errors. And they actively shared safety information with each other, such as the need to take extra care with medicines in similar packaging to others. The pharmacy had a formal incident reporting process and the SI demonstrated how incidents were recorded through the NHS England Learning from patient safety events service (LFPSE) and to the NHS CD accountable officer through a national online reporting tool. A team member reflected on personal learning they had completed following a mistake involving a missed collection of a prescription fee.

The pharmacy advertised how people could provide feedback and raise a concern about the service they received. Team members had a clear understanding of how to manage feedback and discussed how they established people's expectations and would escalate a concern to the SI. The pharmacy was registered with the Information Commissioner's Office. It had procedures available to support its team members in managing confidential information with care. And it stored personal identifiable information on password-protected computers and in staff-only areas of the premises. It disposed of its confidential waste securely. Pharmacy team members completed safeguarding learning to support them in identifying and reporting concerns about vulnerable people. They had access to reporting information and contact details for local safeguarding teams. A team member confidently explained the steps they would take to report a safeguarding concern. They identified how they would refer a request to use a 'safe space' to the RP for support.

The pharmacy had current indemnity insurance. The SI discussed the checks they had made to assure themselves the insurance covered all of the pharmacy's private consultation services, including prescribing. The RP notice on display contained the correct details of the RP on duty. But the notice was displayed prior to the RP arriving at the pharmacy. This gave the impression to people entering the pharmacy that there was a RP on duty as the pharmacy had opened. The RP record was kept electronically. There were multiple sign-in and sign-out times for the same day recorded on some days. The SI explained this was because if the PMR was closed it would sign the RP out and they were required to sign in again. The record also showed RP cover was not consistent with the pharmacy's opening hours with multiple occasions where the RP had signed out before the pharmacy was due to close. No absences were seen to be recorded in the record. The pharmacy held its CD register electronically. Records complied with legal requirements. It completed frequent checks of physical stock held against the running balance in the CD register. Random physical balance checks of CDs completed during the inspection matched the balances recorded in the CD register. The pharmacy held a record of the patient-returned CDs it received. But this was not always updated in a timely manner following receipt or destruction of a CD. The pharmacy held its specials records in accordance with requirements.

The pharmacy team did not always record the correct details of the prescriber or the date the prescription was written when entering private prescriptions into its private prescription register. A recent record for the supply of a human medicine under the veterinary cascade showed it had not been labelled as required. The pharmacy was not recording any of the private prescriptions for its private consultation services. This included prescriptions for vitamin B12 injections written by a third-party prescriber and for its own travel health service. The SI made an electronic record of the medicines they prescribed through the travel health service. But they were unable to show how they retained the

prescription as required.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has a dedicated team of people who work together well. Team members complete learning to support them in providing the pharmacy's services. They understand how to raise concerns at work. And they engage in some ongoing discussions to share ideas and learning.

Inspector's evidence

A qualified dispenser, an apprentice and a trainee pharmacist were working alongside the SI. The pharmacy employed another qualified dispenser, a pharmacy technician who worked in an accuracy checking role (ACPT), and two delivery drivers. A regular locum pharmacist covered the SI's regular day off. The SI felt there was enough flexibility in the team with some team members increasing their hours when required to support both planned and unplanned leave. Workload was managed and up to date. The company did not set specific targets for the services it provided.

The apprentice was enrolled on a GPhC accredited qualification training course. Both trainee team members felt supported in their roles and received protected study time. They were aware of how to raise concerns about their learning or about the support they received. And they knew how to escalate these concerns. Other team members engaged in some continual learning to support them in delivering the pharmacy's services. For example, learning to support their role in providing the NHS Pharmacy First Service. But there were some gaps in the team's knowledge around the RP regulations. The pharmacy had a whistle blowing policy. The SI had provided information to team members about how to raise concerns at work. A team member explained their induction had included information about the GPhC's role as the pharmacy regulator. And they understood how they could raise a concern with the GPhC if required. Team members felt confident to suggest ideas and implement changes at work. They were supported through a structured appraisal process and felt able to feedback during their annual appraisals. Team members shared information through informal conversations. But they did not record the outcomes of these discussions to support them in sharing learning or measuring the effectiveness of any risk reduction actions they took following these conversations.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are secure and maintained to an adequate standard. They provide a suitable environment for providing pharmacy services. The premises include a large purpose-built private consultation space to support people in having confidential discussions with team members.

Inspector's evidence

The pharmacy was secure and appropriately maintained. It used local tradespeople for building works and to resolve maintenance concerns. And team members knew to report any maintenance concerns to the SI. The pharmacy was clean and relatively tidy throughout. Lighting was bright and heating arrangements were appropriate with air conditioning provided on both the ground floor and first floor level of the building. To the side of the pharmacy building was the pharmacy's automated collection point. This was fitted with its own air conditioning unit to ensure any medicines inside the machine were kept in a controlled environment. The pharmacy's public area was fitted with wide spaced aisles. There was a large consultation room accessed to the side of this area. The room had recently been built to support the delivery of the pharmacy's expanding consultation services. The pharmacy used its old consultation room as storage space. Overall, the new consultation room was professional in appearance although some equipment was laid on top of empty wholesaler boxes rather than on work benches or tables which did distract from the professional appearance the room offered.

The pharmacy's main dispensary was behind its medicine counter. The team managed space in the dispensary well and work benches were free of clutter. A door to the side of the public area provided team members with access to the first-floor level of the pharmacy. The first floor provided staff kitchen and bathroom facilities. There was a storeroom and two good size rooms fitted with work benches. One room was used to assemble multi-compartment compliance packs and manage the care home service. The other was used to complete checking tasks and store assembled compliance packs and deliveries going to care homes. The pharmacy had a website which provided details of the owner, the name of the SI and GPhC premises number of the pharmacy. But it did not provide the SI's registration number or details of how people could check the registration status of the pharmacy or SI.

Principle 4 - Services **Standards not all met**

Summary findings

The pharmacy does not have appropriate monitoring arrangements to ensure it is storing medicines requiring refrigeration at the correct temperature. And it does not always store some of its higher-risk medicines securely as required. The pharmacy obtains its medicines from reputable suppliers and overall, its team members follow effective processes and make appropriate records when delivering its services.

Inspector's evidence

The pharmacy was accessed up a step from street level. The SI had considered accessibility and explained they had received planning permission for a ramp. The pharmacy's window displays included information about its services and opening times. Pharmacy team members had good knowledge of the local area and knew how to signpost people to other pharmacies or healthcare services if required. The pharmacy had a tablet device at the medicine counter which allowed people presenting for the Pharmacy First Service to complete a questionnaire for the condition they required advice or treatment for. This supported pharmacy team members in referring people who required a clinical consultation to the pharmacist, or in providing advice on self-care. The pharmacy held its P medicines behind the medicine counter and team members were observed asking appropriate questions when managing requests for these medicines.

The pharmacy's website advertised details of its services. But some information on the website was not accurate. For example, it referred to travel health services in Islington, rather than Brinsley. This had the potential to cause confusion. The pharmacy had relevant information available to support pharmacists in providing its consultation services, such as service specifications and copies of PGDs for its NHS services. The SI provided the pharmacy's private consultation services. They demonstrated the learning they had undertaken to provide these safely and provided information about the checks they made of the third-party providers they worked with, such as checking that prescribers issuing prescriptions for vitamin B12 injections were on the GMC register. They demonstrated the remote support they received from an audiologist when assessing people's ear health prior to an ear irrigation procedure taking place. The SI demonstrated the consultation and record keeping process for the travel health and vitamin B12 service. This included questions about medical history, current medication, therapy specific questions and establishing contact information for a person's own GP. The pharmacy encouraged people to share information about any injections they received at the pharmacy with their own GP but it did not contact people's regular prescribers itself. The pharmacy normally made appointments available for its private services in an afternoon. The SI explained this supported them in managing dispensary services alongside consultation services.

The pharmacy had clear processes for highlighting CDs requiring safe custody and cold chain medicines requiring extra care throughout the dispensing process. And the pharmacy did not store these medicines in its automated collection point. The pharmacy did not routinely identify other higher-risk medicines and those requiring ongoing monitoring during the dispensing process. And it had not undertaken a risk assessment to ensure controls were in place for providing appropriate counselling to people before storing these medicines in its automated collection point. The SI provided examples of how they used safety information when supplying medicines in multi-compartment compliance packs

to ensure medicines could safely be supplied in this way. As a result of these reviews, the pharmacy had deemed a number of medicines as unsuitable for assembly in a compliance pack. The team was aware of the legal changes requiring the supply of valproate to be made in the manufacturer's original pack. The SI understood the requirements of the valproate Pregnancy Prevention Programme (PPP). But they only took the opportunity to record counselling and checks for higher-risk medicines when engaging in clinical audits. This meant there was limited records of these types of interventions to support them in providing continual care.

Pharmacy team members completed a range of audit trails when dispensing medicines. This included signing the 'dispensed by' and 'checked by' boxes on medicine labels to provide an audit trail of their role within the dispensing process. Keeping digital audit trails of the deliveries they made to people's homes and to care homes. And keeping clear records of the medicines the pharmacy owed to people. The pharmacy used baskets throughout the dispensing process. This separated people's prescriptions from others to avoid items being mixed up. The pharmacy kept appropriate records to support it in assembling medicines in multi-compartment compliance packs and supplying medicines to people residing in care homes safely. It recorded key information such as changes to people's medication regimens clearly within their PMR. The pharmacy made medication administration records (MARs) available for all medicines it supplied to people residing in care homes. It provided patient information leaflets when supplying medicines in compliance packs to people living in their own home at the beginning of each four-week cycle. But it only supplied patient information leaflets when supplying medicines in the manufacturer's original packaging to people living in care homes or when a new medicine was added to a person's medication regimen. This may mean that care home teams did not have the most up to date written information about the medicines they were administering to people.

The pharmacy sourced medicines from licensed wholesalers and a licensed specials manufacturer. It mostly stored medicines within their original packaging. A few medicines held in amber bottles had accompanying safety information such full details of the medicine, the batch number and expiry date of the medicine attached to the bottles. Pharmacy team members recorded the periodic safety checks of stock medicines they undertook. This included checking expiry dates and ensuring liquid medicines with short shelf lives once opened were identifiable. A random check of stock held in the dispensary and storeroom found no out-of-date medicines. The pharmacy team did not store or always follow secure processes when managing higher-risk medicines requiring safe custody. The pharmacy had three fridges for storing its cold chain medicines. The fridges were working within the required operating range of two and eight degrees Celsius during the inspection and records of the operating range on this date were recorded on the fridge temperature logs. But prior to the inspection the temperature logs had not been completed since March 2024. This meant the pharmacy could not provide assurances that it had held its cold chain medicines within the required temperature between March and July 2024.

The pharmacy had appropriate medicine waste receptacles and CD denaturing kits available. Several team members talked through the process for disposing of patient-returned and expired medicines safely. The pharmacy required its team members to remove confidential information from medicine packaging and recycle cardboard medicine packaging as part of its sustainability efforts. It participated in manufacturer recycling schemes for used pen devices by making recycling containers available at its medicine counter for people to take. The pharmacy did not always use the kits it had obtained from its reputable wholesalers when disposing of its CDs. For example, it had recently used cat litter to dispose of some recently received patient-returned CDs despite denaturing kits being available. The SI explained the waste medicines had been rendered irretrievable and had been placed in a medicine waste bin and sent for incineration through the pharmacy's usual medicine waste processes. The pharmacy received medicine alerts electronically and it kept an audit trail of the checks it made in response to these alerts.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs for providing its services. Its team members use the equipment and facilities in a way which protects people's confidentiality.

Inspector's evidence

Pharmacy team members accessed a range of hard copy and digital reference resources to support them in answering queries. They used passwords and NHS smartcards to access people's medication records. The pharmacy's computer monitors were suitably protected from unauthorised view through the layout of the premises. It stored bags of assembled medicines out of direct view of the public area.

The pharmacy had a selection of standardised measuring cylinders to measure liquid medicines. Equipment for counting medicines was also available to the team. The pharmacy kept most of the equipment for its consultation services within its consultation room. The equipment was from recognised manufacturers and the SI checked it regularly to ensure it remained in safe working order and cleaning supplies were readily available. But the team did not always clean some of the equipment straight after use, instead it cleaned it prior to its next use. A discussion highlighted appropriate cleaning regimens following the use of equipment for consultation services. The pharmacy had a service contract for its automated collection point with the machine's manufacturer. The team provided examples of how the manufacturer responded in a timely manner to service calls.

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.