General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Ways Pharmacy, 24 Chilwell Road, Beeston, NOTTINGHAM, Nottinghamshire, NG9 1EJ

Pharmacy reference: 1035628

Type of pharmacy: Community

Date of inspection: 24/10/2024

Pharmacy context

The pharmacy is in the Nottinghamshire town of Beeston. Its main services include dispensing prescriptions, selling over-the-counter medicines, and providing a range of consultation services to people including NHS Pharmacy First, blood pressure checks, seasonal flu vaccinations and a private prescribing service. The pharmacy provides some medicines to people in multi-compartment compliance packs designed to help people to take their medicines. And it delivers medicines to people's homes. The inspection took place over two dates, 24 October 2024, and 29 October 2024.

Overall inspection outcome

Standards not all met

Required Action: Statutory Enforcement

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	1.1	Standard not met	The pharmacy does not identify or manage the risks for providing a prescribing service. It has insufficient governance arrangements for providing such a service as there are no risk assessments, procedures or policies in place.
		1.2	Standard not met	The pharmacy does not undertake any audit activity to assure itself that the private prescribing service is provided safely.
		1.5	Standard not met	The pharmacy does not have adequate professional indemnity insurance arrangements for all of its services. The remote consultations for the prescribing service being undertaken by the superintendent pharmacist from the pharmacy are not covered by the current arrangements.
		1.6	Standard not met	The pharmacy's prescriber does not make clear and accurate records for the consultations they undertake when providing the pharmacy's prescribing service. And they do not always issue legal prescriptions for dispensing.
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	4.2	Standard not met	The pharmacy does not manage its private prescribing service safely. It does not show how it suitably verifies information before prescribing and supplying medicines.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

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

Summary findings

The pharmacy identifies and manages the risks for providing most of its services. But it doesn't do this for the private prescribing service it provides. It has no risk assessments or formal governance arrangements for the service. And there is a lack of clear and accurate record keeping for the consultations taking place. The pharmacy's professional indemnity insurance arrangements do not cover virtual appointments despite these taking place regularly. And prescriptions issued through the service do not always comply with legal requirements. The pharmacy advertises how people can provide feedback about its services and it manages people's confidential information with care. Pharmacy team members engage in shared learning following the mistakes they make during the dispensing process. And they know how to identify, and report concerns to help keep vulnerable people safe from harm.

Inspector's evidence

The pharmacy had some standard operating procedures (SOPs) to support its safe and effective running. But there were no SOPs for a prescribing service which commenced in October 2023. The current version of SOPs had been implemented by the superintendent pharmacist (SI) in 2023. New SOPs had been introduced to support the provision of new NHS services such as the Pharmacy First Service. The pharmacy kept training records which indicated team members had signed most procedures relevant to their role. A new team member had started to read the SOPs to support them in their role. A trainee member of the team discussed what tasks could not take place if the RP took absence from the pharmacy. They explained how they would manage feedback, or a concern raised by a person visiting the pharmacy, and how they would escalate this to the attention of the pharmacist. The pharmacy advertised its complaints process to people. It kept a record of any concerns raised about its NHS services, these included the actions taken to investigate and resolve these concerns.

The pharmacy's prescribing service was provided by the superintendent pharmacist (SI), who was a pharmacist independent prescriber (PIP). There had been no consideration of the need to have procedures for the service. And a formal risk assessment had not been conducted to identify and support the pharmacy in managing the risks for operating a prescribing service. Such as, the range of medical conditions and medicines prescribed, the circumstances in which a prescription could be written, prescribing frequencies, the mode of consultation, record keeping and how prescriptions were transferred to the dispensing pharmacy. The pharmacy had also not considered the need to share information with people's regular prescriber when prescribing medicines.

The pharmacy did not have a prescribing policy setting out the scope of the service. And it had not completed any clinical audits or prescribing reviews since launching its service. So, there were missed opportunities to identify any improvements required to the prescribing service. The SI discussed their scope of practice which included women's health. They also stated they prescribed 'what the community needed.' They explained they would not prescribe selective serotonin reuptake inhibitors (SSRIs), an antidepressant. But there was evidence of a prescription for a SSRI being written by the SI and dispensed by the pharmacy. And prescriptions for other medicines used to treat mental health conditions was seen.

The pharmacy had processes for managing mistakes identified during the dispensing process, known as near misses. Following a near miss, team members checked their work again and corrected the mistake. The team kept a record of near misses and they regularly met to share learning and agree actions designed to reduce the risk of similar mistakes occurring. For example, holding some medicines in baskets on the dispensary shelves to prompt team members to slow down and apply extra checks when picking them. The pharmacy had a clear process for reporting mistakes identified following the supply of a medicine to a person, known as a dispensing incident. Incident reports included reflective statements from team members involved, investigations to find the root cause of the mistake and details of the actions taken to reduce risk. For example, the team used flag notes on patient medication records (PMRs) to drawer their attention to important information to help reduce the risk of mistakes during the dispensing process.

The pharmacy had current professional indemnity insurance. The pharmacy's current policy covered most of the activity taking place. But the policy stipulated that it covered face-to-face prescribing services. The PIP conducted some appointments remotely with people visiting another pharmacy in London, this meant some of the consultations conducted through the prescribing service were not face-to-face. There was no evidence of other current professional indemnity insurance, such as personal cover for the PIP provided.

The RP notice on display on both dates of the inspection contained the correct details of the RP on duty on each day. A sample of the RP record found pharmacists routinely signed into the record, but they did not always sign out of the record at the end of the working day to confirm their responsibility had ceased. The pharmacy held its controlled drug (CD) register in accordance with legal requirements. It maintained running balances in the register, and it undertook regular full balance checks of all physical stock against the balances in the CD register. Random physical balance checks of CDs conducted during the inspection complied with the running balances in the register. The team recorded patient-returned CDs at the point of receipt in a separate register.

The pharmacy held its private prescription register electronically. The register complied with legal requirements. The register showed the pharmacy had dispensed 84 medicines from prescriptions written by the PIP. It was also used to record some details of the prescribing consultations taking place. For example, a prescription for a fluconazole 150mg capsules was annotated with details that the patient had confirmed a recent appointment with the diabetic nurse showed no concerns. The PIP had indicated she had discussed the reason for recurrent infection could be due to poor diabetes control. Other forms of record keeping for the prescribing service was extremely limited and took the form of annotations on private prescription forms. The records did not show what information the PIP had gathered to inform their prescribing decision. Only two formal consultation records were seen, one of these records had led to a prescription being issued for three medicines. There was a lack of medical history within the notes and no evidence that the GP had been informed of the consultation and prescription despite the record indicating that the person required referring to their GP for an asthma management plan. Some prescriptions written by the PIP and dispensed by the pharmacy were seen to be legal. But the PIP regularly issued prescriptions which did not meet legal requirements as they did not always sign the prescription in indelible ink. This was the case when they issued prescriptions for dispensing to another pharmacy as a completed prescription template with an image of the PIPs signature was sent to the pharmacy by email to be dispensed. This was not followed up with an original prescription with a wet signature on it. And the pharmacy did not have a system to send valid electronic prescriptions.

The pharmacy had procedures to support its team members in managing confidential information with care. And team members were observed following these procedures. For example, they ensured any

information with personal details on was held in the staff-only area of the pharmacy. The team segregated and disposed of its confidential waste securely. The PIP discussed how they would check a person's identity by asking to see their passport when prescribing to people who were visiting England from abroad without enough medication to last their entire trip. But they did not document these checks or keep evidence of them. Team member had access to helpful information to support them in identifying and reporting concerns about potentially vulnerable people. And they undertook training to help them recognise and escalate any safeguarding concerns they had. They were aware of how to recognise requests from people requiring access to a safe space, and they understood how to act to ensure people received timely access to a safe space should a request be made.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough team members to provide its services. Overall, it supports team members in completing learning relevant to their role. Pharmacy team members work together well, and they feel able to feedback their ideas at work. They engage in regular conversations to help manage workload and to share learning with each other.

Inspector's evidence

The SI worked at the pharmacy the majority of the time. Either a pharmacist director for the company that owned the pharmacy, or a regular locum pharmacist covered their days off and leave. The pharmacy also employed a qualified dispenser, a medicine counter assistant, a driver, and a new team member who was working their way through the pharmacy's induction training. The pharmacist director worked from the premises alongside the SI a lot of the time. They led a team of staff working in a non-registered area of the premises. This team provided a service fulfilling orders for healthcare items, toiletries, and General Sales List (GSL) medicines placed by people living overseas in China.

Pharmacy team members completed some ongoing learning relevant to their roles. For example, training for providing the NHS Pharmacy First Service. The medicine counter assistant was observed undertaking some tasks in the dispensary. The SI provided evidence that the team member had recently extended their role and the pharmacy was in the process of enrolling them on an accredited learning course to support them in their new role. The SI had qualified as a PIP in 2023. They discussed their scope of practice for their prescribing qualification. They explained they completed their prescribing in women's health and that they had completed some continual professional development (CPD) courses since then. There was evidence of learning for the NHS consultation services and a certificate issued to the SI in 2021 for the completion of a CPD course for providing walk-in clinics in community pharmacy. But they did not provide any evidence of specific learning they had completed to support them in prescribing higher-risk medicines such as insulin and medicines for mental health conditions.

Pharmacy team members engaged in regular conversations about workload and patient safety. The team kept some records of these conversations. Topics discussed included discussing new SOPs, safeguarding requirements, and changes to medicine packaging to inform safe dispensing practices. Team members felt confident in providing feedback at work. And they knew how to escalate a concern if required to do so. The pharmacy did not set any specific targets for its team members to meet. The RP on duty on 24 October 2024 described how they contributed to the pharmacy's daily task management to help ensure the team was up to date with its workload.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is appropriately secure and well maintained. It provides a professional environment for the delivery of healthcare services. People visiting the pharmacy can speak in confidence to team members in a private consultation space.

Inspector's evidence

The pharmacy premises were secure from unauthorised access. They were clean and maintained appropriately. Air conditioning helped to maintain an ambient temperature and lighting was bright in most areas. But lighting in the area near the CD cabinets was particularly dim. A discussion with the RP on duty on 24 October highlighted the need to ensure the area was well let to support the team in managing medicines stored inside the cabinets safely. Team members had access to handwashing facilities.

The public area of the pharmacy allowed easy access to both the consultation room and the medicine counter. The consultation room provided a professional space for conducting private consultations. The dispensary was to the side of the medicine counter. It was a good size for the level of activity taking place and workspace was managed well. Team members also had access to staff facilities which led off the side of the dispensary. A door leading from the dispensary lead to an extension, built by the current owners. This space consisted of two rooms, one of which was used to fulfil the orders sent to China. This area was not part of the pharmacy’s registered footprint.

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

Summary findings

Overall, the pharmacy manages its NHS dispensing services well. But it does not manage its private prescribing service safely. It does not show how it obtains necessary information from people before prescribing and supplying medicines through this service. The pharmacy's services are accessible to people, and it obtains its stock from licensed wholesalers. It stores its medicines safely and securely and it makes regular checks to ensure they remain safe to supply. But it does not fully consider the safeguards required before starting a medicine postal service to people living in China. So, it may not be operating this service in the proper way.

Inspector's evidence

People accessed the pharmacy from stairs or a ramp leading from street level. The pharmacy advertised its opening times and details of its services. It also advertised information about local health and social care services in the area. The pharmacy did not have its own website. But its details were advertised on another pharmacy's website. Although different companies owned both of the pharmacies, they worked together to provide their services. This website provided people with the option to start a consultation for a private prescribing service. It did not provide details of the prescriber providing the service. The SI explained that they prescribed to people either face-to-face who attended the pharmacy or through a video consultation only.

The pharmacy had procedures and supportive information available for its NHS consultation services. This information included the service specification, clinical pathways, and patient group directions for the treatment of minor ailments. But it did not have a prescribing policy for its private prescribing service. And formal consultation records for the service were not routinely made. This meant there was very little supporting evidence as to why a prescription was issued. The SI stated they would prescribe insulin to people who travelled from China and had not brought enough with them for their stay. They discussed checking the person's passport when doing this and asking for evidence of their current prescription, such as hospital letter. They explained how they asked a person to sign a document to state they would not drive whilst in the UK and would go over hypoglycaemic control with people to ensure people knew what to do if their blood sugar become low. But there was little evidence to support the checks being made other than some prescriptions which were accompanied by a letter which the team stated was written in Chinese. There were no formal consultation notes for any of the insulin prescriptions seen to be dispensed by the pharmacy.

The SI prescribed a wide range of medicines for people who were not registered with a GP in the UK. Prescriptions for valproate, lorazepam, quetiapine and letrozole were seen to have been written by the SI and dispensed by the pharmacy. Formal consultation notes for these prescriptions were not kept. This meant there was no information about people's medical history, and the decisions about why a treatment was necessary. The majority of these private prescriptions dispensed appeared to be a one off, although a repeat prescription for quetiapine had been issued. There were no records of refusals kept for the service. And there was no insight shown about the need to consider national guidance when prescribing. For example, a prescription for quetiapine had been issued for an indication of 'short term use for sleep disorder' and had been dispensed. The medicine was not licensed for this indication.

The pharmacy identified NHS prescriptions for medicines which were out of stock long term. But in

some cases, instead of informing people's GPs of the stock issue, the pharmacy offered what the SI described as an 'over the counter' consultation service. This involved the SI speaking to people and rewriting their NHS prescription by offering an alternative on a private prescription. For example, issuing prescriptions for atorvastatin 40mg (two tablets daily) due to atorvastatin 80mg being out of stock, candesartan 8mg tablets (two tablets daily) due to candesartan 16mg tablets being out of stock and betamethasone 0.1% cream due to betamethasone 0.1% ointment being out of stock. The pharmacy did not have a written procedure for doing this. It did not keep clear and accurate consultation notes for the service. And there had been no consideration of the need to obtain consent from people to check the National Care Record Service to ensure what was being prescribed was a suitable alternative. Or of the need to inform GPs the NHS prescription could not be dispensed. The process followed by the team included sending a dispensed notification for the NHS prescription meaning people's GPs would see the prescription was dispensed, despite this not being the case.

The pharmacy team used baskets throughout the dispensing process to help keep all medicines with the correct prescription. It kept effective audit trails to show who had been involved in the dispensing process. And it kept records of the medicines it owed to people, when a full quantity could not be supplied, and of the medicines it delivered to people's homes. The pharmacy team had an effective system to support it in managing the supply of medicines in multi-compartment compliance packs to people. This included schedules to support workload management and recording the checks team members made when people's medication regimens changed. The pharmacy supplied patient information leaflets alongside the compliance packs. It recognised that most people receiving their medicines in this way had them delivered, and so it attached helpful notes to assembled bags of medicines as a way of communicating with people. For example, notes to remind people about the importance of contacting the pharmacy should there be a change in their medication regimen. The pharmacy had processes to identify higher-risk medicines it dispensed for NHS prescriptions. And it managed the supply of these medicines when dispensing these prescriptions well with intervention records made on people's medication record detailing the information provided to people when counselling them about the safe use of their medicine. A team member discussed changes to the valproate pregnancy prevention programme (PPP) which required the medicine to be supplied in the manufacturer's original packaging only.

The pharmacy obtained its medicines from a variety of licensed wholesalers. It sold some products to people who lived in China. A pharmacist director explained this activity involved selling healthcare items, toiletries and GSL medicines and was a separate part of the business. The pharmacy however obtained the stock to fulfil these orders through its regular wholesalers and as such was associated with the supply of these products. Some packaged orders contained multiple boxes of some GSL medicines, including some medicines containing paracetamol. The pharmacist director stated they did not think export licenses were required to send these medicines to China in this way. But they had not undertaken checks with the Medicines and Healthcare products Agency (MHRA) to check this was the case. And they had not considered the need to introduce maximum quantities when supplying the medicines. The pharmacist director stated they would take this feedback onboard to inform the safe provision of these products moving forward.

The pharmacy stored its medicines in an orderly manner. It held medicines requiring cold storage in a medical fridge. And it monitored and kept a record of the operational temperature range of the fridge to ensure medicines were stored at the right temperature. The pharmacy held its CDs securely in cabinets, medicines inside were stored in an orderly manner. Pharmacy team members conducted regular stock management checks, including reviewing the expiry dates of medicines. They recorded these checks and highlighted medicines with short-expiry dates, and they recorded the date of opening on liquid medicines to prompt additional checks when dispensing. No out-of-date medicines were found during a random check of dispensary stock. The pharmacy had medicine waste bins available for

the safe disposal of any returned medicines or out-of-date medicines. The pharmacy received alerts about medicines that may not be fit for purpose by email. And it kept an audit trail of the action it took in response to these alerts.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

Overall, the pharmacy has the appropriately maintained equipment and facilities it needs to provide its services. And its team members use the equipment in a way which protects people's confidentiality.

Inspector's evidence

Team members used a range of reference resources, most of which they accessed digitally. They used passwords and NHS smart cards to access people's medication records. The pharmacy stored bags of assembled medicines safely, and in a way which prevented sharing personal information on bag labels and prescription forms with unauthorised personnel.

Pharmacy team members had access to appropriate telephone equipment to support them in maintaining people's confidentiality when speaking to them on the telephone. They used a range of equipment to support them in delivering the pharmacy's services. This included standardised equipment for counting and measuring medicines. It clearly marked and stored equipment for counting and measuring higher-risk medicines separately. The pharmacy kept most of the equipment to support its consultation services in its consultation room. The team explained that stock of adrenaline autopens kept in the dispensary would be used in an emergency if needed. A discussion highlighted the need to ensure the team had immediate access to adrenaline, which was not included within dispensing stock when providing a vaccination service to ensure there was no risk of it being out of stock. Equipment seen was from reputable manufacturers and clean. But some equipment in the consultation room was no longer in use and had expired, the team confirmed this would be removed from the room.

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.