General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Acorn Pharmacy, 8-10 Main Road, Jacksdale, NOTTINGHAM, Nottinghamshire, NG16 5JW

Pharmacy reference: 1035692

Type of pharmacy: Community

Date of inspection: 22/01/2020

Pharmacy context

This is a community pharmacy in a small village on Nottinghamshire's border with Derbyshire. The pharmacy sells over-the-counter medicines and dispenses NHS prescriptions. It offers advice on the management of minor illnesses and long-term conditions. It supplies some people with medicines in multi-compartment compliance packs, designed to help them remember to take their medicines. And it delivers medicines to people's homes.

Overall inspection outcome

✔ **Standards met**

Required Action: None

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Summary of notable practice for each principle

Principle	Principle finding	Exception standard reference	Notable practice	Why
1. Governance	Standards met	1.8	Good practice	Pharmacy team members have a sound understanding of their role in protecting vulnerable people. And they act to protect the welfare of these people by reporting and documenting their concerns.
2. Staff	Standards met	2.2	Good practice	The pharmacy is particularly good at encouraging team members to engage in continual learning relating to their roles. It does this by supporting in-house learning and attendance at regular learning events which help to develop team members skills.
3. Premises	Standards met	3.2	Good practice	The pharmacy's private consultation room is well designed to support the safety of those using it. And pharmacy team members actively promote the availability of the room.
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 generally keeps all records it must by law. It advertises and responds to feedback about its services appropriately. Pharmacy team members act openly and honestly by sharing information when mistakes happen during the dispensing process. And they regularly share learning and make changes to their practice to improve patient safety. They have a sound understanding of their role in protecting vulnerable people. And they act to protect the welfare of these people by reporting and documenting their concerns.

Inspector's evidence

The pharmacy had a set of standard operating procedures (SOPs). The superintendent pharmacist (SI) confirmed these had last been reviewed in May 2019 by himself and a pharmacy technician. Some, but not all SOPs were annotated with details of this review. There was evidence of the pharmacy introducing new SOPs in response to changes. For example, it had drafted a new SOP relating to the Falsified Medicines Directive (FMD). And it had implemented a Serious Shortage protocol (SSP) SOP. Other SOPs covered responsible pharmacist (RP) requirements, controlled drug (CD) management, services and dispensing tasks. SOPs included the roles and responsibilities of pharmacy team members. And most members of the team had read and signed them. The newest member of the team was working under full supervision of a second member of staff whilst being inducted into the pharmacy. The SI confirmed the next step was for her to begin reading and signing the SOPs.

Workflow in the dispensary was efficient. Pharmacy team members completed labelling and assembly tasks in different areas of the dispensary. And there was a designated area used for accuracy checking medicines. To the side of the main work area were two good sized work benches. And tasks associated with the supply of medicines in multi-compartment compliance packs took place on these benches. This provided a relatively distraction free area for this high-risk activity.

The pharmacy team members recorded details of near misses into a near miss record book. Mistakes were brought to their attention by a pharmacist. And 'in the moment' learning was preferred to help apply timely action to help reduce risk. The near miss record contained details of this learning and the follow-up actions taken to reduce risk. For example, separating different strengths and formulations of the same medicines in the dispensary. Some different formulations of medicine were further separated into different areas of the dispensary to further reduce the risk of a picking error. For example, ramipril capsules were located in the fast-moving section of the dispensary, and ramipril tablets had been moved to shelves at the other side of the dispensary. A trainee dispenser checked each item she picked against a prescription with a second member of the team before starting the assembly process. She explained how this helped inform her understanding of the medicines and reduced the risk of a near miss occurring. An annual patient safety review supported the team in monitoring the actions taken to reduce risk.

The pharmacy had an incident reporting procedure. This involved reporting the incident through the National Reporting and Learning System (NRLS). Minor details of the error were then recorded in the near miss record along with a reference number of the NRLS submission. The SI reflected on an incident

involving a delivery error. The pharmacy had investigated the incident to ensure the dispensing process had not contributed to it. And the member of staff involved had completed reflective learning following the mistake.

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. A member of the team explained how she would manage and escalate a concern to the pharmacist if required. The pharmacy engaged people in feedback through an annual 'Community Pharmacy Patient Questionnaire'. And it published the results of its most recent questionnaire for people to read.

The pharmacy had up-to-date indemnity insurance arrangements in place through The National Pharmacy Association (NPA). The RP notice on display contained the correct details of the RP on duty (the SI). Entries in the responsible pharmacist record were generally completed in accordance with requirements. But there were a few missed sign-out times observed in the sample of the record examined. Samples of specials records and private prescription records complied with legal and regulatory requirements. The pharmacy held its CD register electronically. It maintained running balances in its register. And full balance checks took place frequently. Physical balance checks of several morphine preparations complied with the balance recorded in the register. The pharmacy also maintained a patient returned CD register electronically. And this was kept up to date.

The pharmacy displayed a privacy notice. And pharmacy team members had completed learning associated with confidentiality and the General Data Protection Regulation (GDPR). The pharmacy had submitted its latest NHS Data Security and Protection (DSP) Toolkit as required. It stored all personal identifiable information in staff only areas of the pharmacy. And it used a cross-shredder to safely destroy confidential waste.

The pharmacy had procedures and information relating to safeguarding vulnerable adults and children. And contact information for local safeguarding teams was available. Pharmacy team members had completed safeguarding learning. The SI confirmed both pharmacists had completed level two learning on the subject. A pharmacy team member demonstrated a sound knowledge of how to recognise and report safeguarding concerns. And she explained she would always refer any concerns to the RP. The team member provided several examples of how the team had acted to report concerns when necessary. And provided an example of how a concern was recorded appropriately on a person's medication record.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has a committed and knowledgeable team that works hard to provide its services effectively. The pharmacy responds appropriately when additional staffing resources are required to support the safe running of the pharmacy. It promotes how its team members can provide feedback. And it acts appropriately by responding to this feedback. The pharmacy is particularly good at encouraging team members to engage in continual learning relating to their roles. It does this by supporting in-house learning and attendance at regular learning events which help to develop team members skills.

Inspector's evidence

On duty during the inspection was the SI, a qualified dispenser, a trainee dispenser and a medicine counter assistant. The pharmacy also employed two pharmacy technicians. Both pharmacy technicians were on planned long-term leave. The SI explained the current staffing situation along with feedback from the team had led him to review staffing levels. The trainee dispenser had been employed to support the team. And the SI confirmed there was some contingency arrangements in place with two other qualified dispensers who had previously worked at the pharmacy, should unplanned leave occur. A delivery driver was employed to provide the medication delivery service. And the pharmacy used a regular locum two days each week.

There was a good commitment to continual learning. The trainee was due to be enrolled on her accredited training course, she had been working at the pharmacy for just over a month. She explained how she felt well supported and was confident in asking questions to support her learning. Another member of the team confirmed she felt well supported at work. Pharmacy team members regularly attended learning events together outside of work. And the dispenser explained how she applied learning from these events. For example, training associated with data protection had led the team to think about and apply new ways of checking people's identification. Pharmacy team members received an annual appraisal. And a member of the team explained the SI would often test team members understanding by posing scenarios which tested their knowledge of SOPs and medicines.

Pharmacy team members were observed supporting each other well. And they greeted many people visiting the pharmacy by name. A number of meaningful conversations took place between pharmacy team members and people visiting the pharmacy during the inspection. All team members spoken to were enthusiastic about their roles. And they engaged well in the inspection process. The SI confirmed he did not set specific targets for services or prescription numbers. But he rewarded team members for their hard work by arranging social events such as bowling or evening meals. The pharmacy had a whistleblowing policy. And two team members spoken to about feedback confirmed they knew how to raise and escalate a concern if necessary. A member of the team provided an example of how feedback about staffing levels had been taken into consideration by the SI.

The pharmacy did not hold structured team meetings. But team members were provided with information through continual informal conversations. This included information relating to patient safety and workload management. Notices on the wall in the dispensary provided visual aids to team members about the risks associated with 'look-alike and sound-alike' (LASA) medicines. And a team

member explained how this information prompted additional checks during the dispensing process. The team had also separated some of the LASA medicines in the dispensary drawers to avoid the risk of selection error.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean and secure. It offers a professional environment for delivering healthcare services. The pharmacy's private consultation room is well designed to support the safety of those using it. And pharmacy team members actively promote the availability of the room.

Inspector's evidence

The pharmacy was professional in appearance and it was secure. It was clean throughout. The public area was fitted with wide spaced aisles. And it was accessible to people using a wheelchair or pushchair. The SI explained how he specifically designed the soundproof consultation room with safety in mind for both people using the pharmacy and for staff seeing people alone in the room. The pharmacy had a chaperone policy and team members encouraged people to use a chaperone when attending for clinical services, such as flu vaccinations. A member of the team would act as a chaperone when requested. The room was professional in appearance and clean. It was sign-posted and well promoted. And it was seen to be used with people during the inspection. The room was secured against unauthorised access between use.

The dispensary was located at the back of the premises. An open-plan window at the front of the dispensary allowed acute prescriptions to be passed to the team. And it supported pharmacists in monitoring activity taking place at the medicine counter and in the public area. The dispensary was an appropriate size for the level of activity observed. Work benches were free of clutter and floor spaces were clear of trip hazards. Off the side of the dispensary was staff toilet facilities. The pharmacy used floor level and electric heaters to heat the premises. Lighting throughout the pharmacy was sufficient. Pharmacy team members reported maintenance concerns to the SI. Local tradespeople were used to manage concerns. The SI demonstrated how immediate action had recently been taken to secure an internet connection, following an incident outside the pharmacy which had left local businesses and homes with no connection.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy advertises its services and ensures these are accessible to people. It obtains its medicines from reputable sources. And it stores and manages its medicines safely and securely. Pharmacy team members follow the pharmacy's procedures when delivering services. And they work effectively with other healthcare providers. This helps to ensure people receive timely access to the medicines they require. But they do not always supply information leaflets when dispensing medicines in multi-compartment compliance packs to help people take their medicine safely.

Inspector's evidence

The pharmacy was accessed through a power-assisted door at street level. It advertised details of its opening times and services clearly within window displays. And it provided further details of its services in a practice leaflet. The pharmacy provided healthy living information to people through leaflets and displays in the public area. Designated seating was available for people waiting for a prescription or service. And pharmacy team members were aware of the requirement to signpost people to another pharmacy or healthcare provider should the pharmacy not be able to provide a service or supply a medicine.

The pharmacy had taken part in an NHS pilot service for the testing and treatment of non-complicated urinary tract infections in 2019. The RP provided examples of how the service had benefited people visiting the pharmacy who were not able to access their GP. He also provided examples of how people would visit the pharmacy for advice about their symptoms in the first instance. This had resulted in interventions when a person required immediate hospital attention and other cases where the pharmacy was able to provide a medicine through the minor ailments scheme, without the need for the person to see their GP.

The SI demonstrated the up-to-date minor ailments protocol, this included patient group directions (PGDs) for the supply of some medicines through an NHS ear, nose and throat service. PGDs for all services requiring them were accessible through PharmOutcomes. And the SI demonstrated how useful this was, as he could refer directly to the PGD during a consultation. The pharmacy was healthy living accredited. A dispenser and the SI led on this aspect of the service. And the dispenser explained how she applied new skills she had learnt through healthy living training events. For example, she was confident in assessing and demonstrating inhaler techniques with people.

The pharmacy had some processes for identifying people on high-risk medicines. It was engaging in audits associated with the NHS Pharmacy Quality Scheme (PQS) for high-risk medicines. The SI explained how verbal counselling and monitoring checks took place with people on these medicines. But the outcomes of the counselling was not recorded. The pharmacy had valproate warning cards available to supply to people in the high-risk group in accordance with the requirements of the Valproate Pregnancy Prevention Programme (PPP). The pharmacy was not supplying valproate preparations to any person in the high-risk group regularly. But its team members were aware of how to identify people requiring a pregnancy prevention plan. And knew to refer these prescriptions directly to the attention of a pharmacist.

The pharmacy used coloured baskets throughout the dispensing process. This kept medicines with the correct prescription form and helped inform workload priority. Pharmacy team members signed 'dispensed by' and 'checked by' boxes on medicine labels to form a dispensing audit trail during the dispensing process. The pharmacy kept original prescriptions for medicines owing to people. The team used the prescription throughout the dispensing process when the medicine was later supplied. The pharmacy maintained an audit trail for the prescription delivery service and people signed to confirm they had received their medication. It also maintained an audit trail for prescriptions it ordered. A dispenser explained the pharmacy was able to order prescriptions from Nottinghamshire surgeries following a request from a person. But it was only able to order prescriptions from Derbyshire surgeries for vulnerable people. The audit trail allowed the pharmacy to manage and resolve any queries prior to collection and delivery dates.

The pharmacy had a robust dispensing process for managing the supply of medicines in multi-compartment compliance packs. It managed the dispensing of these packs in one monthly cycle. The dispensing process involved a pre-check of the selected medicine against the prescription and patient profile sheet prior to packs being assembled, regular dispensing and accuracy checks took place. And another check of the assembled pack pre-delivery was completed by team members. This last check helped to ensure any external items such as creams and inhalers were supplied alongside the packs. Changes to people's medication regimens were checked and recorded on the monthly planner sheet. A sample of assembled packs found that backing sheets were not printed with the required adverse warnings associated with the medicines inside the pack. A discussion took place about labelling requirements and a member of the team followed this up immediately and rectified the issue during the inspection. The sample of packs contained full dispensing audit trails. The pharmacy provided descriptions of the medicines inside the packs to help people identify them. But it did not routinely supply patient information leaflets at the beginning of each four-week cycle of packs. The team were informed of the requirement to supply these leaflets in accordance with The Human Medicines Regulations 2012.

The pharmacy sourced medicines from licensed wholesalers and specials manufacturers. Pharmacy team members had some awareness of FMD. The pharmacy had purchased and installed equipment ready to comply with the directive. And it was registered with SecurMed. But it had not physically begun to scan medicines with FMD compliant packaging. The pharmacy received drug alerts by email. Details of alerts were recorded on an alert and incident log in the dispensary along with other matters affecting business continuity. For example, the recent loss of the internet. Details of the steps taken in response to the alerts was recorded.

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 most were held within their original packaging. But some medicines on a shelf in the multi-compartment compliance pack area of the dispensary were held in amber bottles. And the bottles did not contain full information of the medicines inside. The SI explained this was not routine practice, and he had not seen this done before. Another member of the team confirmed the team had acted to remove the medicines from a pack the day prior to inspection. And was not sure what to do with them. A discussion took place about the risks associated with storing medicines in this way. And the SI provided assurance he would share learning from the event with team members.

The pharmacy held CDs in secure cabinets. Medicines were generally kept in a safe and orderly manner inside the cabinets. But the stock cabinet was reaching capacity. The pharmacy team members marked CD prescriptions. And they were observed applying vigilance when handing out these medicines. For

example, checking prescription validity periods. The pharmacy's medical fridge was a suitable size for the amount of medication stored inside. Temperature records confirmed the fridge was operating between two and eight degrees Celsius as required. But there were some minor gaps in recording in January 2020.

The pharmacy had a date checking rota. This was followed to help ensure short-dated medicines were identified. A random check of dispensary stock found no out-of-date medicines. But pharmacy team members did not always annotate bottles of liquid medicines with details of their opening date or shortened expiry date where appropriate. This meant it could be more difficult for a pharmacist to assure themselves that open bottles of liquid medicines remained safe and fit to supply. An open bottle of Sytron oral solution was brought to the attention of the SI. The pharmacy had medical waste bins and CD denaturing kits 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. And it regularly monitors and replaces equipment to ensure it remains in working order. Pharmacy team members manage and use the equipment in a way which protects people's confidentiality.

Inspector's evidence

The pharmacy had up-to-date written reference resources available. These included the British National Formulary (BNF) and BNF for Children. Pharmacy team members also had access to the internet which provided them with further resources. The pharmacy's computers were password protected. And information on computer monitors was protected from unauthorised view due to the layout of the pharmacy.

The pharmacy stored assembled bags of medicines in a retrieval system in the dispensary. And it stored prescriptions relating to the assembled bags of medicines within a file close to the retrieval area. These processes helped to protect the confidentiality of people using the pharmacy's dispensing service. Pharmacy team members used NHS smart cards to access people's medication records. And they used a cordless telephone handset when speaking to people over the telephone. This allowed them to move out of earshot of the public area when discussing confidential information over the telephone.

Crown stamped measuring cylinders were in place for measuring liquid medicines. And these included separate measures for use with methadone. The pharmacy team used a counting machine for counting most tablets and capsules. A dispenser confirmed it was accuracy checked each month. But recent cleaning and accuracy checks had not been recorded. The pharmacy also had separate counting equipment available for use when counting cytotoxic medicines. It had the necessary equipment readily available to support the supply of medicines in multi-compartment compliance packs. It had a blood pressure machine from a reputable manufacturer. This had been replaced within the last year. An otoscope was also available to support the ear, nose and throat service. The pharmacy's electrical equipment contained information confirming it had been safety tested in March 2019.

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.