General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Well, 137 Nottingham Road, Selston, NOTTINGHAM, Nottinghamshire, NG16 6BT

Pharmacy reference: 1035697

Type of pharmacy: Community

Date of inspection: 07/11/2019

Pharmacy context

This is a community pharmacy in a large village on the border between Nottinghamshire and Derbyshire. The pharmacy sells over-the-counter medicines and dispenses NHS prescriptions and private prescriptions. It offers advice on the management of minor illnesses and long-term conditions. And it delivers medicines to people's 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	1.1	Standard not met	The pharmacy team is struggling to complete the workload required. And this has led to shortcuts to the way it provides some of its services. And inappropriate management of space in the dispensary.
2. Staff	Standards not all met	2.1	Standard not met	The pharmacy authorises its team members to work overtime. But it does not have the staffing profile to cover the overtime on some occasions. And some pharmacists providing cover at the pharmacy do not have prior training relating to the pharmacy's offsite dispensing service. There is evidence this has impacted on workflow in the dispensary. And the way the team completes some tasks.
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 team members do not always follow the pharmacy's procedures. They do not keep detailed records of prescription requests they make. And they do not always effectively deal with any queries that result from this. And the pharmacy team does not always complete the checks that will identify any issues with the offsite dispensing service. This means the pharmacy may miss opportunities to identify and manage queries or safety concerns.
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 some of the risks associated with its services. But the pharmacy team is struggling to complete the workload required. And this has led to shortcuts to the way it provides some of its services. And inappropriate management of space in the dispensary. The pharmacy keeps people's private information secure. And it responds to feedback it receives about its services. Pharmacy team members act openly and honestly by sharing information when they are notified of mistakes made during the dispensing process. They are knowledgeable about how to act to protect the safety and wellbeing of vulnerable people. The pharmacy generally keeps all records it must by law. But some very minor gaps in these records occasionally result in incomplete and inaccurate audit trails.

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 they completed learning through watching videos and completing assessments to confirm their understanding of each SOP. The pharmacy manager demonstrated training records which confirmed the team had completed all relevant learning to date. SOPs included the roles and responsibilities of pharmacy team members. And staff were observed labelling and assembling medicines in accordance with the SOPs. A dispenser confirmed what tasks could and could not take place if the responsible pharmacist (RP) took absence from the pharmacy. The pharmacy was closed as the inspector arrived and pharmacy team members were observed answering queries at the door. This was due to the expected RP taking unplanned absence. A locum pharmacist arrived to cover the pharmacy and was in the process of signing in and establishing the safe and effective running of the pharmacy as the inspection began.

The dispensary was small. And the team used floor space to hold baskets of assembled medicines waiting for accuracy checks. A team member confirmed this was standard practice as the pharmacy did not have enough shelves to hold its workload waiting to be checked. A discussion took place about the risks associated with this practice. And the practice was discouraged. Most work bench space was taken up. A work bench in the staff room beyond the dispensary was clear. There was space for labelling and assembling acute workload and managed workload. And there was protected space for the pharmacist to complete accuracy checks of medicines.

The pharmacy had a near-miss error reporting procedure. Pharmacy team members explained they tried to record these types of mistakes on a paper record in the first instance. And then transfer them to an electronic recording system 'Datix'. The pharmacy had fallen behind in transferring the records to Datix recently and this had been picked up during the regional support managers recent audit. Pharmacy team members explained they recorded the details of near-miss errors they were made aware of. But explained they had found some locum pharmacists correcting mistakes and not feeding back to team members. The team members confirmed they prompted pharmacists to feedback to them to help their learning. The pharmacy also used Datix to record details of dispensing incidents. These were clearly recorded. And pharmacy team members explained how they shared information to help reduce errors through their working practices. For example, sharing details of 'look-alike' and 'sound-alike' medicines when unpacking the medicine order.

The pharmacy used Datix to assist in producing a monthly patient safety review. The review for October 2019 was outstanding as the manager explained the pharmacy were waiting for input from a company employed relief pharmacist. Previous reviews had been completed in good time. The team had documented key safety information relating to trends in mistakes and the actions taken to reduce risk. The pharmacy team also shared learning relating to prescribing incidents, interventions and drug alerts during their patient safety review. Pharmacy team members confirmed the review involved a huddle where they could contribute their ideas to managing risk.

The pharmacy had a complaints procedure. It advertised how people could provide feedback or raise a concern about the pharmacy. And pharmacy team members could explain how they would respond to a concern. Feedback relating to prescriptions not being ready on time had increased significantly within recent months. The pharmacy team explained how they had responded to this feedback by sharing information about dispensing timescales with people. And encouraging people to order their prescriptions in good time. The pharmacy had also stopped ordering some prescriptions through its 'free repeat prescription service' (FRPS). This service had been stopped by the NHS Clinical Commissioning Group (CCG) in Derbyshire. But the pharmacy had also changed arrangements for some practices within Nottinghamshire after a mutual decision between the practice and pharmacy. Pharmacy team members explained they had tried to verbally inform people of the changes.

The pharmacy had up-to-date indemnity insurance arrangements in place. The RP notice displayed contained the correct details of the RP on duty. The sample of the RP record examined was generally compliant with legal requirements. There was a missed sign-out time on 05 November 2019. Samples of specials records, emergency supply records and private prescription records complied with legal and regulatory requirements. The pharmacy maintained running balances of CDs within its CD register. And it completed full balance checks against physical stock most weeks. A physical balance check of MST Continus 5mg tablets complied with the balance of the CD register. The pharmacy maintained a patient returned CD register. And pharmacy team members generally wrote returns into the register on the date of receipt. Some returned Zomorph 30mg capsules were found in the CD cabinet during the inspection. These had been labelled as returns but were not entered in the register. The manager acted to complete this record.

The pharmacy displayed a privacy notice. It had procedures relating to information governance and compliance with data protection requirements. 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. And it had used 'Shred-it' bags to store confidential waste. These were sealed and collected for secure disposal periodically.

The pharmacy had procedures and information relating to safeguarding vulnerable adults and children. It displayed a chaperone notice. And the pharmacy had contact information for safeguarding agencies. Pharmacy team members completed safeguarding learning through e-learning. The RP demonstrated he had completed level two training through the Centre for Pharmacy Postgraduate Education (CPPE). And the manager confirmed she had also completed level two training. A pharmacy team member demonstrated a sound understanding of safeguarding requirements and discussed how she would recognise and report a concern. The delivery driver understood the requirement to report concerns back to the pharmacy team. And the pharmacy shared minor concerns relating to medicine compliance with surgery teams.

Principle 2 - Staffing **Standards not all met**

Summary findings

The pharmacy has a small team with a vacancy waiting to be filled. It does not have the staffing profile to always cover the overtime authorised. And some pharmacists providing cover at the pharmacy do not have prior training relating to the pharmacy's offsite dispensing service. And there is evidence that this has impacted on workflow in the dispensary. And the way the team completes some tasks. Permanent members of the pharmacy team are committed, and complete ongoing learning associated with their roles. And pharmacy team members share learning and show how they apply changes to their practice following feedback.

Inspector's evidence

On duty during the inspection was the RP, the manager (a pharmacy technician) and two qualified dispensers (pharmacy assistants). A company employed driver provided the pharmacy's medication delivery service. Staffing levels had reduced since the last inspection in 2015. And the manager confirmed the pharmacy had lost 33 hours due to the introduction of offsite dispensing. The pharmacy sent just under half of its prescription item numbers to the offsite dispensing hub pharmacy.

The regular pharmacist had left in August 2019. Locums predominately covered the opening hours of the pharmacy with some support from the area relief team. The pharmacy manager had raised concerns about staffing levels and this had resulted in a 16-hour post being made available. The pharmacy manager was contracted to work 39 hours a week and 54 hours was shared between the two dispensers. The manager reported working up to 54 hours in recent weeks to help the team keep on top of workload. Some backfill support was provided by members of the dispensing relief team. But pharmacy team members explained this was removed at short notice on some occasions and on other occasions cover had been switched to a different period in the day. This had resulted in staff having to cancel personal plans and had affected their work/life balance. The pharmacy had overtime authorised. But it did not always have the capacity to cover this overtime with the current staff profile. The pharmacy manager had very recently accepted a new job and was due to leave the pharmacy following her notice period.

Pharmacy team members were managing to keep on top of dispensing workload. But they explained that tasks often got behind schedule in the pharmacy. For example, it was reported that some locum pharmacists took up to three times longer to complete clinical and accuracy checks associated with the off-site dispensing service as they were unfamiliar with the service. And the team demonstrated how prescriptions which required part-dispensing at the pharmacy and part-dispensing at the central hub had been misplaced due to this unfamiliarity. This had further increased the time required for managing the service. Pharmacists did have a guide to the off-site dispensing model readily available at their checking station.

Pharmacy team members regularly completed learning associated with their roles. The pharmacy did not provide protected learning time for this. Team members explained they tended to complete this learning in their own time. But they confirmed they could ask for time if required. And the pharmacy regularly monitored learning to ensure it was completed in a timely manner. Pharmacy team members received an annual appraisal and confirmed they felt well supported by their manager. For example, the

manager had spent extra time going through changes to a new clinical software programme the pharmacy had fitted earlier in the year.

Pharmacy team members were observed liaising well with people visiting the pharmacy. Pharmacy team members were aware of targets the pharmacy had for its services. The pharmacy had recently been given a 'Focus Fortnight' which had involved completing three New Medicine Service (NMS) and ten flu vaccinations a day. The manager expressed that the pharmacy had not managed to meet the target. And expressed how pharmacists had managed services using their professional judgement during this time.

Pharmacy team members worked well together. The pharmacy had a whistle blowing policy and a confidential help line where staff could seek support if required. The pharmacy team had an open approach to sharing feedback. And confirmed they were able to escalate concerns if necessary. The team confirmed that it had been provided with some response relating to the concerns raised over staffing. Pharmacy team members communicated well with each other. They shared learning through regular 'huddles' and demonstrated how this safety information informed their practice. For example, by applying thorough self-checks of their work.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises are secure and are maintained to the standards required. Working areas are generally clean. But some areas can become cluttered during busy periods of the day. The pharmacy has private consultation facilities in place. These help to protect the confidentiality of people accessing its services.

Inspector's evidence

The pharmacy was professional in appearance and it was secure. The public area was small, but it was open plan. This provided accessibility to people using wheelchairs and pushchairs. There was seating provided for people waiting for prescriptions or services. The pharmacy had a sign-posted consultation room to the side of the public area. Pharmacy team members had raised some concerns about being able to overhear some conversations in the room. And in response to this the pharmacy had fitted some sound-proofing to help reduce the noise carrying. Pharmacy team members explained they were vigilant to noise levels when the room was in use. And the room had a hearing loop which reduced the need to speak loudly. The room was a sufficient size and it was equipped with the necessary resources to support pharmacy team members in delivering the pharmacy's services.

The dispensary was small and required the team to work together well to manage the space available. The manager identified improvements to space which the team had implemented following changes to its dispensing model, to accommodate the offsite dispensing. The pharmacy team had created additional storage space for bags of assembled medicines through re-arranging stock. The team confirmed requests for additional shelving in the dispensary had been escalated through their regional manager to avoid the need to store baskets at floor-level. But these requests had not been approved. Pharmacy team members explained the situation worsened during busy afternoons when labelling and assembly tasks were completed quicker than accuracy checks. The pharmacy did have a back room which was used to hold some stock and records. And this had a small work bench which was not used. The room also provided a break area for staff and a sink for reconstituting liquid medicines. Off this room there was staff toilet facilities.

The pharmacy was heated through fan heaters at floor level. A metal gate across the back door had been fitted to help increase ventilation over summer months. Lighting was sufficient throughout the premises. Pharmacy team members completed all cleaning tasks. And the pharmacy was clean. Antibacterial hand wash and paper towels were provided at the sink in the staff toilet. Team members reported maintenance concerns to their head office. There were no outstanding maintenance issues noted on the day of inspection.

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

Summary findings

The pharmacy has up-to-date procedures to support the pharmacy team in delivering its services. But these are not always followed. The pharmacy team members don't keep detailed records of prescription requests they make. And they don't effectively deal with any queries that result from this. And the pharmacy team doesn't always complete the checks that will identify any issues with the offsite dispensing service. This means the pharmacy may miss opportunities to identify and manage queries or safety concerns. The pharmacy advertises it services well and it obtains its medicines from reputable sources. It keeps its medicines safe and secure.

Inspector's evidence

The pharmacy was located next to other NHS health services. Free onsite parking was provided. There was step-free access into the pharmacy. And a bell was available for people to ring if they required help with access. The pharmacy advertised details of its opening times. Its services were advertised through notices and leaflets available in the public area and consultation room. The pharmacy was promoting an antibiotic awareness campaign and the flu vaccination service on the date of inspection. Pharmacy team members used their own local knowledge and information available on the internet to help signpost people to other healthcare organisations when required.

Prescription bags were annotated with stickers to help identify eligible people for some of the pharmacy's services. For example, Medicines Use reviews (MURs). The pharmacy had up-to-date patient group directions (PGDs) to support the flu vaccination service. But the PGD for the supply of emergency hormonal contraception (EHC) was not up to date. No records of recent supplies were found. And the manager confirmed people were signposted to the surgery if they required the free service. The manager was aware of how to locate an up-to-date copy of the PGD should the service recommence.

Pharmacy team members had completed learning associated with the supply and management of cytotoxic medicines. They used stickers on assembled bags of medicines to identify the need for monitoring checks associated with the supply of high-risk medicines such as warfarin. This prompted referral to the pharmacist for verbal counselling. But the pharmacy did not regularly record details of the monitoring checks on people's medication records. The pharmacy team was knowledgeable about the requirements of the valproate pregnancy prevention programme (PPP) and warning cards were readily available to issue to people in the high-risk group.

The pharmacy's FRPS service was not being managed in accordance with the SOPs. Pharmacy team members had ceased using the FRPS record cards to record the details of what was being ordered. This meant they could not apply checks of the prescriptions received against a record of what had been ordered. As a result of this the pharmacy had managed queries about missing items by referring people back to their surgery. The service was advertised as a convenient way for people to manage their medicines. A discussion took place about the risks associated with not applying checks of the prescriptions received. This conversation included the potential of missing a change to a person's medication which would require further checks. And the expectations of people using the service. Pharmacy team members were clear that they had been instructed to cease using the FRPS records by a

senior manager. This was because they had raised concerns about the time impact on managing the service. This practice was not in accordance with the SOP for the service. And following the inspection the superintendent's team confirmed the pharmacy should not be operating the service in this way. And it was established that miscommunication about any changes required had occurred at some stage during the review of the service.

The team had completed training and competency tests prior to sending prescriptions to the company's hub as part of its central fulfilment service. And pharmacy team members demonstrated a clear understanding of their roles associated with this service. Feedback about some aspects of the service had been taken onboard to help improve workflow. The pharmacy followed the company's 'Best in Class' guidance for managing some parts of this service. The 'Best in Class' was a tool designed to support teams in following SOPs and managing risks when delivering the pharmacy's services. Pharmacy team members used an electronic scanning device which tracked the prescription through the entire dispensing process. If part of the prescription was sent to the hub and part was dispensed locally, it clearly provided details of where each packet of assembled medicines was stored prior to hand out. This mitigated the risk of people only being supplied with part of their prescription. Pharmacists did not engage fully in the requirement to complete 'Post-hub' checks. This process should have involved the RP checking one complete hub dispensed prescription, one part-hub dispensed prescription and one locally dispensed prescription each day. The records associated with these checks showed a number of gaps. This restricted the pharmacy's ability to monitor the service.

The pharmacy used coloured baskets throughout the dispensing process. This kept medicines with the correct prescription form and helped inform workload priority. 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 asked people to sign for receipt of their medicines through the prescription delivery service.

The pharmacy sourced medicines from licensed wholesalers and specials manufacturers. Pharmacy team members discussed changes to medicine packaging introduced due to the Falsified Medicine Directive (FMD). They had completed some learning on the subject and discussed the safety checks they applied to tamper proof packaging during the dispensing process. But the pharmacy had not yet received details of when it would begin scanning and decommissioning medicines.

The pharmacy stored Pharmacy (P) medicines behind the medicine counter and behind Perspex casing to the side of the counter. This meant the RP had supervision of sales taking place and was able to intervene if necessary. The pharmacy stored medicines in the dispensary in an organised manner. The pharmacy team followed a date checking rota to help manage stock and it recorded details of the date checks it completed. The team had missed several checks in August 2019 but had completed all checks for September and October 2019. It had begun date checking for November 2019. Short-dated medicines were identifiable. But the team did not routinely annotate details of opening dates on bottles of liquid medicines with shortened shelf lives once opened. Several bottles of open liquid medicines with three-month expiry dates once opened were segregated and bought to the attention of the manager. Medical waste bins, clinical waste bins and CD denaturing kits were available to support the team in managing pharmaceutical waste. Pharmacy team members explained how the arrangements for managing medical waste had greatly improved following the manager requesting additional resources to contain the waste.

The pharmacy held CDs in a secure cabinet. Medicine storage inside the cabinet was orderly. There was designated space for storing patient returns, and out-of-date CDs. Pharmacy team members demonstrated how CD prescriptions were highlighted to prompt additional checks during the

dispensing process. The pharmacy's fridge was clean and stock inside was stored in an organised manner. But the fridge was full to capacity and as such storage arrangements required for cold chain medicines required monitoring closely. The pharmacy team monitored fridge temperatures. But there were gaps in these records where several days at a time had been missed. Minimum and maximum temperature records either side of these gaps remained within the required operating range of between two and eight degrees Celsius. The pharmacy stored both assembled CDs and cold chain medicines in clear bags within the fridge and CD cabinet. This helped prompt additional safety checks upon supply.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has all the equipment and facilities it needs for providing its services. And pharmacy team members manage and use 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. The pharmacy team members had access to the company intranet and internet which provided additional reference resources. Computers were password protected and information on computer monitors was protected from unauthorised view due to the layout of the pharmacy. Pharmacy team members used NHS smart cards to access people's medication records. The pharmacy stored assembled bags of medicines to the side of the dispensary. This protected people's private information against unauthorised view. The pharmacy's telephone handsets were cordless. This meant they could move out of ear-shot of the public area when having confidential conversations with people over the telephone.

Clean, crown stamped measuring cylinders were in place for measuring liquid medicines. And these included separate measures for use with methadone. The pharmacy had clean counting equipment for tablets and capsules, including a separate counting triangle for use when counting cytotoxic medicines. It had the necessary equipment readily available to support its flu vaccination services. And it had a working blood pressure machine. But the blood pressure machine was annotated with a sticker showing it had been due to be checked in October 2019. The machine was used strictly for screening purposes. And people were referred to their GP for additional checks if results were abnormal. Stickers on electrical equipment showed portable appliance checks were next due in September 2020.

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.