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: 30/07/2024

Pharmacy context

The pharmacy is next to a GP surgery in the large Nottinghamshire village of Selston. Its main services are dispensing prescriptions and selling over-the-counter medicines. It provides a range of consultation services to support people's health needs, including the NHS blood pressure check service, NHS New Medicine Service and NHS Pharmacy First Service. It provides a medicine delivery service to people's homes.

Overall inspection outcome

✔ **Standards met**

Required Action: None

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Summary of notable practice for each principle

Principle	Principle finding	Exception standard reference	Notable practice	Why
1. Governance	Standards met	N/A	N/A	N/A
2. Staff	Standards met	N/A	N/A	N/A
3. Premises	Standards met	N/A	N/A	N/A
4. Services, including medicines management	Standards met	N/A	N/A	N/A
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance ✔ Standards met

Summary findings

Overall, the pharmacy acts effectively to identify and manage risks associated with providing its services. It mostly keeps the records it needs to by law. And it keeps people's confidential information secure. The pharmacy supports its team members in applying learning to help reduce the risk of mistakes occurring during the dispensing process. Pharmacy team members understand their role in managing feedback and responding to concerns. And they have the knowledge to recognise, and report concerns to help keep vulnerable people safe.

Inspector's evidence

This inspection was prompted by intelligence received by the GPhC. The pharmacy had recently had a turnover of all team members at the same time. This had contributed to two days of closures in late June 2024. The responsible pharmacist (RP) on duty on the day of inspection was an experienced pharmacist and manager. The company that owned the pharmacy had arranged for the RP to lead on a programme of improvements and temporarily relocate from their own pharmacy following the events of June 2024. The RP provided full details of the improvements they had made, and those that the team were still working through. They explained the focus from day one of their placement was on providing services safely and following standard operating procedures (SOPs).

The pharmacy had a range of SOPs to support its safe and effective running. Its superintendent pharmacist's team reviewed these on a rolling two-year cycle, and it introduced new SOPs ahead of the pharmacy providing new services. Pharmacy team members accessed the SOPs electronically and completed records of their learning for the SOPs to show that they had understood them. All team members were new in post, the area manager was currently working fulltime in the pharmacy to support the safe delivery of pharmacy services. They discussed the protected learning time and support they made available to the new team members to complete their learning. And they demonstrated their learning records which showed a sensible approach to learning with mandatory learning such as information governance and SOPs for tasks relevant to their roles completed first. A team member discussed the tasks that could not take place in the event the RP took absence from the pharmacy.

The pharmacy had processes for managing mistakes identified during the dispensing process, known as near misses. And for managing mistakes identified following the supply of a medicine to a person, known as dispensing incidents. Patient safety reports showed a decline in reporting following the pharmacy's team leader leaving in Spring 2024. As all team members were new to their roles, the RP had held a patient safety review meeting in July 2024 to introduce team members to the importance of acting openly and honestly when a mistake occurred. The patient safety review had also focussed on important medicines safety updates, drug recalls and compliance with pregnancy prevention programmes (PPPs). The RP had shared details of identified risks with the team, and team members worked with care to manage these risks. For example, some medicines on the dispensary shelves were not stored in a tidy row due to stock levels being higher than needed. They were managing this by reviewing medicine orders and reducing stock levels where needed. And by making additional checks when picking medicines to help reduce the risk of them picking the incorrect medicine. Team members had also applied recent learning following an adverse event brought to light after the events of June 2024 to improve the way it managed prescriptions for medicines that it owed to people.

The pharmacy had procedures to support people in providing feedback and raising concerns about the pharmacy. The new team had initially dealt with a lot of feedback about people's experiences in June 2024. The team explained how they used this feedback to help drive improvement and to reduce the risk of people experiencing a similar situation in the future. The team reported that feedback levels had reduced significantly as the month had gone on. Waiting times throughout the inspection were minimal and people were observed engaging positively with pharmacy team members. The pharmacy had safeguarding procedures available to its team members. And several team members, including the delivery driver, identified how they would recognise and report these types of concerns. The RP and area manager had completed formal safeguarding learning whilst working for the company. And a new dispenser had also completed safeguarding learning in their last place of employment. The RP demonstrated the information they had available to them to support them in contacting safeguarding teams and raising concerns.

The pharmacy stored all personal identifiable information in the staff-only area of the premises. All team members engaged in mandatory information governance learning, and they understood the importance of treating people's confidential information with care. The pharmacy had secure processes for disposing of its confidential waste. It had current indemnity insurance. The RP notice on display contained the correct details of the RP on duty. And the RP record was generally completed in full, but a company-employed pharmacist using remote access to provide the NHS New Medicine Service (NMS) had signed in as the RP on more than one occasion. This had led to some records showing two RPs on duty which was inaccurate. The team generally made effective records of the private prescriptions it dispensed. One record from May 2024 could not be found within the private prescription register. The area manager discussed the need to make some additional checks of the record to ensure there were no further missed entries. The pharmacy held its controlled drug (CD) register electronically. It maintained running balances, there had been a gap with the completion of balance checks prior to the new team taking over the pharmacy. The team was now completing frequent balance checks of physical stock against the balances recorded 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 in a separate section of the register at the point of receipt.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough staff with the appropriate knowledge and skills to deliver its services. It is effectively supporting the new pharmacy team in working through improvements and changes to ensure it delivers its services safely and effectively. Pharmacy team members are supported in their learning roles, and they benefit from some protected learning time at work. They engage in discussions designed to help identify and manage risk. And they know how to raise concerns and provide feedback at work.

Inspector's evidence

The RP on duty was working with the area manager (a dispenser), another qualified dispenser and a trainee pharmacy assistant. Both the qualified dispenser and trainee pharmacy assistant were new to their role, but they both had previous pharmacy experience. The pharmacy's delivery driver was also on duty for a small part of the inspection. The pharmacy had recruited another team member who was due to join the team in the next few weeks and it had also recruited a permanent pharmacist. The area manager was new to their role, and they discussed feeling supported by another area manager and the pharmacy's regional operations manager. The team was up to date with its workload and there was some forward planning to support the RP in handing over to the new permanent pharmacist. The area manager discussed plans to gradually decrease the level of support they were providing to the team as staffing levels and skill mix stabilised. The pharmacy management team was monitoring workload carefully. The team was up to date with current workload and was coping well.

New team members were working through formal induction learning. They felt confident in asking questions at work. And they were supervised well and fully supported by the RP and the area manager. The team communicated through informal briefings at the beginning of the day to discuss workload, any feedback received and to focus on any tasks requiring immediate attention. They had engaged in one formal patient safety review to date, with more planned as part of the pharmacy's monthly review processes. The pharmacy had a whistleblowing policy and it provided access to a confidential employee assistance programme for its team members. All team members on duty knew how to provide feedback and raise concerns at work. They understood the importance of escalating their concerns if they felt they needed to, and they discussed how they could do this. The RP demonstrated through conversation how they were fully able to apply their professional judgement in the best interests of people using the pharmacy. They explained that the current focus was on ensuring pharmacy services were safe and effectively managed.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean and secure. It provides a professional environment for the delivery of pharmacy services. People using the pharmacy can speak with a member of the pharmacy team in a private consultation room.

Inspector's evidence

The pharmacy was clean and secure. The pharmacy premises consisted of an open plan public area, the dispensary, a consultation room, and staff facilities. The pharmacy's consultation room was clearly signposted. It was small but it was professional in appearance, and it was clean and clutter free. The dispensary was small, but it offered enough space for team members to safely manage dispensing tasks. Workbenches were clean and tidy between dispensing tasks. And floor spaces were free of trip hazards. The team completed some higher risk dispensing tasks, such as preparing liquid medicines in the staff kitchen, off the back of the dispensary. This provided a protected space which helped to reduce risk when dispensing these medicines.

The pharmacy was heated by fan heaters at floor level and portable fans were in use in the summer months. Lighting and ventilation throughout the premises were sufficient. The pharmacy was well maintained, recent building works had been completed following the premises being closed for around a year up to June 2024 due to an accident that had affected the structural integrity of the building. The pharmacy had traded from a temporary registered pharmacy premises within its carpark during this time. There were no current maintenance or health and safety concerns. The team knew how to raise maintenance requests should it need to do so. The pharmacy's sinks were equipped with antibacterial hand wash and paper towels. And workstations throughout the pharmacy were equipped with hand sanitiser.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy is accessible to people. It obtains its medicines from reputable sources. And overall, it stores its medicines safely and securely. Pharmacy team members make regular checks to ensure medicines are safe to supply to people. And they provide people with relevant information about their medicines to help them take them safely.

Inspector's evidence

People accessed the pharmacy through power-assisted doors at street level leading from the onsite carpark. The pharmacy advertised its opening times and details of its services for people to see. Team members knew how to signpost people to other healthcare services or pharmacies if required. The RP provided examples of the communication they had with people's key workers when the pharmacy was required to close its doors. These conversations had supported people in obtaining their medicines temporarily from another local pharmacy.

The pharmacy stored Pharmacy (P) medicines behind the medicine counter. The RP had appropriate supervision over the medicine counter and public area and the trainee pharmacy assistant was observed bringing requests for P medicines to the RPs direct attention. The pharmacy had information available to team members to support them in providing services safely. For example, service specifications, procedures, and current Patient Group Directions (PGDs) to support pharmacists in providing the NHS Pharmacy First Service. But the PGDs had not been signed by pharmacists providing this service. The RP explained their records were held at their usual place of work. They kept a wealth of information and learning records available to them on their mobile phone to support them in delivering consultation services safely. Pharmacy team members were attentive to people's needs and took the time to engage people in conversations about their health and the medicines they were taking.

The RP discussed the requirements of the valproate PPP, including the need to supply valproate in original containers. They discussed the counselling they would provide if they dispensed prescriptions for valproate to people within the at-risk group. The RP was knowledgeable about the number of people the pharmacy dispensed higher-risk medicines requiring additional monitoring to. And they discussed the counselling and monitoring checks they completed when handing out these medicines. But they did not regularly take the opportunity to record these types of verbal interventions on people's medication records to support continual care. The area manager demonstrated how the team was able to run a report to show all dispensing activity for specific medicines, and they explained how this information supported the team to complete clinical audits.

Pharmacy team members used coloured baskets throughout the dispensing process. This process kept medicines with the correct prescription form and identified those for priority dispensing. They took ownership of their work by signing their dispensing signatures within the 'dispensed by' and 'checked by' boxes on medicine labels. The team used barcode technology which tracked the entire dispensing process. This supported it in identifying where a prescription was and in locating bags of assembled medicines to handout to people. The pharmacy used electronic audit trails when delivering medicines to people. This supported team members in answering any queries that arose about the service. It kept prescriptions for the medicines it owed to people neatly within a filing system. And team members

were making regular checks with wholesalers to help ensure people received these owed medicines in a timely manner. The team discussed concerns about medicine availability with the GP surgery to help ensure prescriptions for alternatives could be considered if local pharmacies were unable to source a medicine.

The team sent some of its workload to the company's offsite dispensing hub pharmacy. This process saw team members enter data from prescriptions into the PMR, the data entry was accuracy checked by the RP on duty. The RP also undertook a clinical check of prescriptions prior to transmitting the data to the company's offsite dispensing hub pharmacy. Some prescriptions were part-dispensed locally and part-dispensed by the offsite dispensing hub pharmacy. The company encouraged team members to complete local dispensing tasks prior to assembled medicines returning from the dispensing hub pharmacy. The RP explained the team was working towards achieving this but currently it was dispensing these medicines after assembled bags of medicine were returned from the hub. This process was seen to be managed well and the pharmacy's SOP allowed for this flexibility in the workflow.

The pharmacy obtained its medicines from licensed wholesalers. Due to stock levels being higher than required some medicines were not stored in the most orderly manner on the dispensary shelves. The team had also identified that checks on medicine expiry dates had last been completed in April 2024. To support it in managing this risk, team members were conducting extra checks when picking medicines. The team had noted that these additional checks were helping to reduce the number of near misses made. There was a clear plan to ensure stock management tasks were brought up to date prior to the RP finishing their placement at the pharmacy. And date checking tasks in the retail area had recommenced. The team marked liquid medicines with details of their opening dates to ensure they remained safe and fit to supply. The pharmacy kept CDs securely in cabinets. Medicines inside the cabinets were kept in an orderly manner with designated space for holding assembled medicines, date-expired and patient-returned CDs. The pharmacy's two medicine fridges were nearing their storage capacity. The team was in the process of reviewing stock levels in the fridges to help ensure there was enough room to store vaccinations safely ahead of the flu vaccination season beginning. There were several gaps in the fridge temperature record. Records between these checks showed the fridge was operating between two and eight degrees Celsius as required. And recent records were seen to be completed in full. The pharmacy had appropriate medical waste receptacles to support the safe disposal of medicine waste. It received medicine alerts electronically and it was required to respond to these alerts by confirming the checks it made. The area manager was working through several recent alerts during the inspection.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it requires for providing its services. It makes checks to ensure equipment is in safe working order. And its team members use the equipment in a way which maintains people's confidentiality.

Inspector's evidence

Pharmacy team members had access to current reference resources and to the internet to support them in obtaining information and providing advice to people. For example, a team member was observed accessing the electronic medicines compendium and printing a patient information leaflet to issue to a person when dispensing a split box of antibiotics. They used password- protected computers and used NHS smart cards to access people's medication records. The pharmacy protected confidential information on its computer monitors from unauthorised view appropriately. It stored bags of assembled medicines on shelving behind the medicine counter and front part of the dispensary. This arrangement effectively protected people's personal information from unauthorised view.

The pharmacy had a range of standardised equipment for counting and measuring medicines. The equipment was clean and separate equipment was available for use when counting and measuring higher-risk medicines. The pharmacy had a good range of equipment available within its consultation room to support the delivery of NHS consultation services. The equipment was from recognised manufacturers, and it was cleaned between use. The pharmacy made regular checks to ensure its equipment was safe to use. For example, its blood pressure machines were marked to confirm they had been recently checked and were in working order. And the pharmacy's electrical equipment was subject to periodic safety testing.

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.