General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Manns Pharmacy, 852a Woodborough Road, Mapperley, NOTTINGHAM, Nottinghamshire, NG3 5QQ

Pharmacy reference: 1035762

Type of pharmacy: Community

Date of inspection: 05/01/2023

Pharmacy context

The pharmacy is on a main road in the Nottingham city suburb of Mapperley. Its main services include dispensing NHS prescriptions and selling over-the-counter medicines. The pharmacy supplies some medicines in multi-compartment compliance packs, designed to help people remember to take their medicines. And it offers a medicine delivery service.

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

The pharmacy appropriately identifies and manages the risks associated with its services. It keeps people's private information secure. And it generally keeps the records it must by law. The pharmacy advertises how people can provide feedback about its services. Pharmacy team members understand how to recognise and respond to safeguarding concerns. And they engage in some conversations to help reduce risk following mistakes made during the dispensing process.

Inspector's evidence

The pharmacy had standard operating procedures (SOPs) in place. They covered responsible pharmacist (RP) requirements, controlled drug (CD) management, dispensary processes and services. The SOPs generally reflected current practice, but they had been due for review during the COVID-19 pandemic. Team members had completed learning associated with the SOPs. And they were observed working in accordance with them when completing tasks associated with dispensing prescriptions. A team member explained what tasks they couldn't complete if the RP took absence from the pharmacy. The team had refreshed their understanding of the importance of recording and learning from adverse events following the last inspection of the pharmacy in June 2022.

Pharmacists provided feedback to team members following mistakes found and corrected during the dispensing process, known as near misses. The team recorded these on a near miss tracker, and they submitted the tracker to the superintendent pharmacist regularly. This helped to ensure the team was consistently recording and learning from these types of events. Pharmacy team members regularly discussed their mistakes and they demonstrated recent actions taken following near misses. For example, they had placed warning labels on shelves containing medicines in similar packaging. And they had separated some medicines on the dispensary shelves to reduce the risk of a picking error occurring. The pharmacy team engaged in reporting and learning processes involving mistakes found after a medicine had been supplied to a person, known as dispensing incidents. The team provided evidence of incident reporting. And they discussed how learning had been shared to reduce the risk of a similar incident occurring following a person receiving another person's medicine.

The pharmacy had a complaints procedure. This was advertised on a notice in the public area of the pharmacy. Pharmacy team members understood how to manage feedback and escalate a concern to either the RP or superintendent pharmacist (SI). They were observed engaging with people politely and treating them with respect. Pharmacy team members had engaged in some learning relating to safeguarding vulnerable people. They understood how to recognise a safeguarding concern. Safeguarding procedures were available along with contact information for local safeguarding teams.

The pharmacy had up-to-date indemnity insurance arrangements in place. The RP notice displayed was changed at the beginning of the inspection to reflect the correct details of the RP on duty. Other pharmacy records examined were generally made in accordance with legal and regulatory requirements with some minor omissions noted. These omissions did not raise safety concerns. For example, some RP sign-out times were missing from the RP register. The pharmacy maintained running balances within its CD register. And it completed monthly physical balance checks of all CDs against the register. The pharmacy had procedures in place to support the safe handling of people's private information. The

team generally held personal identifiable information on a computer and within the dispensary. It shredded confidential waste onsite.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has suitably skilled and knowledgeable people working to provide its services safely and effectively. It has appropriate support systems to help members of the pharmacy team in learning roles. And pharmacy team members regularly reflect on their practice by sharing learning following adverse events. They work together well to manage workload. And they are aware of how they can raise a professional concern at work.

Inspector's evidence

The RP was a regular locum pharmacist who worked at the pharmacy two days each week. The pharmacy had reviewed its staffing level and skill mix since the last inspection. And as a result, the team now consisted of a full-time qualified dispenser in the role of pharmacy supervisor, a part-time qualified dispenser, a full-time apprentice, working towards a NVQ level two qualification in pharmacy services and a part-time delivery driver. Regular locum pharmacists provided cover at the pharmacy. Team members from the company's other pharmacies provided some support on some occasions.

Pharmacy team members appeared happy and confident in the roles. The apprentice reported to be progressing through their course. And they received protected learning time at work to support them in their role. Other team members had engaged in some learning associated with risk management and some requirements of the NHS Pharmacy Quality Scheme. And the supervisor had received induction training led by the pharmacy owner when they had joined the team. Pharmacy team members communicated well with each other throughout the inspection. And they were observed supporting each other when managing workload. The pharmacy did not have specific targets associated with the delivery of its services. And the RP confirmed they felt supported in applying their professional judgment whilst working at the pharmacy.

Pharmacy team members shared learning following mistakes through conversations. These conversations led to actions being implemented to reduce risk. But they did not engage in structured team meetings to support them in measuring the effectiveness of these actions. Members of the pharmacy team understood how to raise a concern at work. And they could contact the SI or owner when needed. They demonstrated several examples of how they had implemented changes following team discussions with regular pharmacists. But some feedback relating to cardboard waste mounting up and being stored in the pharmacy had not been acted upon.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are secure, and the team maintains its working areas appropriately. People using the pharmacy can speak with a member of the pharmacy team in confidence in a private consultation room.

Inspector's evidence

The pharmacy was suitably secure against unauthorised access when it was closed. It was clean but some fittings were worn. For example, the carpet in the public area of the pharmacy. And cardboard waste was stored in a corner within the public area of the pharmacy. This was not a health and safety concern, but it was not in keeping with the professional image expected of a healthcare setting. Lighting throughout the premises was bright. The pharmacy had a range of heaters for use during colder weather. Hot and cold water was available alongside antibacterial hand wash, alcohol hand gel and towels at sinks. The dispensary was small for the work activity carried out. But team members used space efficiently. There was designated bench space for completing dispensing and checking tasks. Staff break facilities were provided in small rooms beyond the dispensary.

The open plan public area of the pharmacy stocked health related items and toiletries. A gate at the medicine counter prevented unauthorised access into the dispensary. A private consultation room was available to the side of the public area. The room was accessible to people, and it was clean and organised. Due to limited storage room, the pharmacy used another secure storage area close by. It used this area to store some retail stock, and dispensary sundries. The team had made significant efforts to review what was stored in this area and to organise the area following the last inspection of the pharmacy. But there were multiple boxes of single-use multi-compartment compliance packs open. This meant there was an increased chance that the contents of the open boxes could be exposed to dust and pest contamination due to the area in which they were stored. A discussion highlighted the need for ongoing monitoring checks associated with storage arrangements in this area.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's services are accessible to people. It obtains its medicines from licensed sources. And it stores its medicines safely and securely. Pharmacy team members engage people in conversations about their health and their medicines. But they do not always supply information leaflets for all medicines. This may limit the information some people have available to support them in taking their medicines safely.

Inspector's evidence

The pharmacy was accessed through a simple door, up a small step from street level. The public area of the pharmacy was accessible to people. And it provided seating for people waiting for prescriptions or other pharmacy services. The pharmacy received some referrals through the NHS Discharge Medicines Service. Team members took the opportunity to reflect on positive outcomes relating to this service and the NHS New Medicine service. They were aware of how to signpost people to another pharmacy or healthcare provider if they were unable to provide a service. The pharmacy was in the process of phasing out its managed repeat prescription service. It had printed out notices to inform people of this, and team members actively discussed the need for people to order their own prescriptions with their surgery moving forward when they collected their medicine.

The pharmacy protected P medicines from self-selection as it displayed them behind the medicine counter. This meant the RP could supervise sales taking place. The pharmacy was currently engaging in a valproate safety audit to support it in meeting the requirements of the valproate pregnancy prevention programme (PPP). It had not dispensed valproate to any person within the at-risk group since beginning the audit. The team confirmed they would use the healthcare professional guide to support it in meeting the requirements of the PPP should it receive a prescription for a person in the at-risk group. A discussion took place about the safe placement of labels and detachable patient cards, and how to order new patient cards. The pharmacy had other tools to support pharmacists in counselling related to higher-risk medicines such as warfarin, methotrexate, and lithium. The RP explained that the patient medication record (PMR) prompted checks associated with these medicines. But the pharmacy did not regularly record these types of interactions on people's medication records.

The pharmacy used baskets throughout the dispensing process. This kept medicines with the correct prescription form. And pharmacy team members took ownership of their work by signing their initials in the 'dispensed by' and 'checked by' boxes on medicine labels. The pharmacy kept original prescriptions for medicines it owed to people. The team used the prescription throughout the dispensing process when the medicine was later supplied. It kept audit trails to support the delivery of medicines to people's homes. The pharmacy did not require people to sign for receipt of all medicines through the delivery service. But it did ask people to sign to accept the receipt of CDs.

Work associated with the multi-compartment compliance pack service was suitably managed with dispensing audit trails completed. A work schedule tracked tasks associated with the service and pharmacy team members had access to a hard copy of people's medication regimen to support the dispensing process. This clearly identified each medicine and time of day it should be taken. The sheets were regularly updated when changes occurred along with entries on the PMR to reflect these changes.

A sample of assembled compliance packs found dispensing audit trails applied to packs and pharmacy team members took care to ensure descriptions on backing sheets matched the brand of medicine they dispensed. But an issue with the quantity printed on backing sheets associated with the packs was identified. This meant the quantity printed did not match that of the prescription or reflected what was actually dispensed into the pack. The cause of the issue was identified within the PMR system, and this was rectified on the day of inspection. The pharmacy issued patient information leaflets on some occasions when supplying medicines in a compliance pack. But this was not routinely done at the beginning of each four-week medication cycle. This meant people may not always have up-to-date information about the medicines they were taking.

The pharmacy stored some higher-risk medicines in a locked cabinet. The cabinet was exceptionally full. But medicines inside were generally held in an organised manner. For example, out-of-date medicines were labelled and clearly identifiable within the cabinet whilst they awaited destruction. The pharmacy held cold chain medicines in a medical fridge. The fridge was clean, but it was also nearing its storage capacity. There were some minor gaps within the fridge temperature record. But the temperature range either side of these gaps had remained within two and eight degrees Celsius as required.

Pharmacy team members carried out date checking tasks across all stock. But they only kept a written record of checks associated stock in the public area of the pharmacy and P medicines. This meant it could be more difficult for the team to monitor how often it was checking dispensary stock. Stickers on medicines helped to highlight those with a short shelf life. The team annotated liquid medicines with the date of opening. This informed additional safety checks during the dispensing process. The pharmacy had appropriate medical waste bags available, and it stored these appropriately between collections. The pharmacy received medicine alerts through email, and it kept an audit trail of appropriate checks made in response to these alerts.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs for providing its services. And its team members act responsibly by using the equipment in a way which protects people's confidentiality.

Inspector's evidence

Pharmacy team members had access to both electronic and written reference resources. These included the British National Formulary (BNF) and the BNF for Children. They also used the internet to help resolve queries and to obtain up-to-date information. The pharmacy's computers were password protected. And information displayed on the computer monitors was not visible from the public area. The pharmacy stored bags of assembled medicines in a way which protected people's personal details from public view. It had a range of equipment available to support the delivery of its services. And separate equipment for measuring and counting higher risk medicines was available.

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.