

# Registered pharmacy inspection report

**Pharmacy Name:** Well, Stapenhill Health Centre, Fyfield Road,  
Stapenhill, BURTON-ON-TRENT, Staffordshire, DE15 9QD

**Pharmacy reference:** 1036879

**Type of pharmacy:** Community

**Date of inspection:** 17/09/2019

## Pharmacy context

This is a busy community pharmacy located next door to a medical centre in the Stapenhill area of Burton-On-Trent. Most people who use the pharmacy are registered at the medical centre next door. The pharmacy dispenses NHS prescriptions and provides other NHS funded services. The pharmacy team dispenses medicines into multi compartment compliance packs for some people to help them to remember to take their medicines.

## Overall inspection outcome

✓ **Standards met**

**Required Action:** None

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
<b>1. Governance</b>	Standards met	N/A	N/A	N/A
<b>2. Staff</b>	Standards met	N/A	N/A	N/A
<b>3. Premises</b>	Standards met	N/A	N/A	N/A
<b>4. Services, including medicines management</b>	Standards met	N/A	N/A	N/A
<b>5. Equipment and facilities</b>	Standards met	N/A	N/A	N/A

## Principle 1 - Governance ✓ Standards met

### Summary findings

The pharmacy has recently increased its efforts to learn from things that go wrong. But prior to this, dispensing incidents were not normally recorded or reviewed. So some learning opportunities may have been missed. The pharmacy team has written instructions to help make sure it works safely. And the team understands its role in protecting and supporting vulnerable people.

### Inspector's evidence

There had been a high turnover of staff in recent months and the pharmacy was often relying on relief staff. This had caused a lack of continuity and caused some operational difficulties. A temporary branch manager had just been appointed.

A range of standard operating procedures (SOPs) were in place which covered the operational activities of the pharmacy and the services provided. SOPs were reviewed by head office on a cyclical basis and new SOPs were uploaded onto each staff members e-learning account. An e-test and declaration were completed at the end of each training module. Compliance with SOP training for the relief team was tracked by their line manager so the responsible pharmacist (RP) could be assured that relief dispensers or pharmacy technicians had received training on the most up-to-date version of the SOPs. The relief pharmacy technicians and dispensing assistant were up-to-date with their SOP training.

Since the new branch manager had started at the pharmacy he had been using near miss logs to record all near miss incidents. The dispenser involved was responsible for correcting their own error to support ongoing learning. Near miss recording before this was sporadic and there was no evidence of the near miss logs being reviewed for patterns or trends. The owners preferred their pharmacies to use of an online recording system for near misses and this was something the branch manager was planning to implement, as well as a monthly review of near misses. Dispensing errors would be recorded using the online recording system. The branch manager, pharmacy technicians and dispenser were aware of company processes and procedures so gave examples of what they would do in various situations and what they had done in other branches.

Members of the team were knowledgeable about their roles and discussed these during the inspection. A new member of staff working on the medicines counter had previously practiced as a pharmacist but was taking a career break, so she was not on the GPhC register. A member of staff answered questions related to medicine sales and responsible pharmacist absence correctly. Pharmacy staff were wearing uniforms and name badges which stated their job role.

A complaints procedure was in place. The branch manager explained the process for handling a complaint or concern. He identified that he would speak to the person first to try to resolve the issue and would provide contact details for head office if the complaint was unresolved. The pharmacy gathered customer feedback by completing an annual customer survey and the results of the previous survey were on display to customers. The pharmacy team were working on improving the operational procedures to make the pharmacy better for the people that used it. There were many positive comments heard throughout the inspection which suggested that these improvements were benefiting people, such as, repeat prescriptions being ready to collect when people came into the pharmacy, medicines being in stock when people thought they would need to come back and less time waiting to

be served at the counter.

The pharmacy had up-to-date professional indemnity insurance in place. The Responsible Pharmacist (RP) notice was prominently displayed and the RP log complied with requirements. Controlled drug (CD) registers also complied with requirements. A regular CD balance check now took place and was documented in the CD register. This had become more regular recently. A random balance check matched the balances recorded in the register. The balance check for methadone was done every week and the manufacturer's overage was added to the running balance. A patient returned CD register was in place. Private prescription and emergency supplies were recorded in a record book and records were in order. Specials records were maintained with an audit trail from source to supply. NHS Medicines Use Review (MUR) consent forms were signed by the patient.

Confidential waste was stored separately to normal waste and sent offsite for destruction. No confidential information could be seen from the customer area. Pharmacy staff completed annual e-Learning training on data protection as part of their compliance training. An NHS Smartcard belonging to a pharmacy technician had the passcode written on, but this was removed when the risk of unauthorised access was pointed out. All the pharmacy staff had completed a Centre for Pharmacy Postgraduate Training (CPPE) training package on safeguarding. A dispenser explained the warning signs she would look out for in vulnerable adults and children. The branch manager had not researched the local safeguarding contacts but said he would look for these on the internet if they were required.

## Principle 2 - Staffing ✓ Standards met

### Summary findings

There are enough staff and they are suitably trained for the jobs they do. But there has been a high turnover of staff in recent months and the pharmacy relies heavily on the relief team. This lack of continuity has caused some operational difficulties. But the pharmacy is actively recruiting to provide a longer-term solution.

### Inspector's evidence

During the inspection, the pharmacy team comprised of a temporary branch manager (RP), two pharmacy technicians, a pharmacy student and a medicine counter assistant. The pharmacy technicians and pharmacy student were from the relief team and were not permanently working at the branch. The medicine counter assistant had started with the company the previous week and, whilst she had a pharmacy degree, she was due to be enrolled on a medicines counter assistant course and dispensing assistant course to be compliant with GPhC minimum training requirements after her induction period.

This pharmacy has been through a difficult period over the last few months and the staff members present during the inspection were either working in the branch temporarily or were very new to the company. The salary budget and core rota had been reviewed when the branch had started to use a hub pharmacy for dispensing repeat prescriptions. The permanent staff had either resigned, were on sickness absence or maternity leave. A temporary branch manager had been working at the pharmacy for around 10-days and has been seconded from his usual pharmacy until the regular pharmacist returns from maternity leave in early 2020. The branch manager was being supported by dispensers and pharmacy technicians from the relief team and a new member of staff had been recruited to work on the medicines counter. The branch manager had been made aware of the problems in the branch prior to agreeing to a secondment and had been tasked at addressing these issues. The relief team were also very supportive of the branch manager and explained how they were helping him in making improvements, such as, organising the multi-compartment compliance pack dispensing process and reducing stock levels. The branch manager had identified that the relationship between the pharmacy and the surgery next door required improvement. So, he had met with the practice manager and some of the GP's to listen to their frustrations about the pharmacy and discuss how they could work together.

The branch manager explained the long-term plan for staffing in the branch. The regular pharmacist was due to return from maternity leave in early 2020, a branch manager (non-pharmacist) had been recruited from another company and was due to start in October and have a two- or three-month induction, there were two dispensing assistant vacancies advertised (30-hours each) and the dispenser on long term absence would either return or this would become another vacancy. Head Office had completed a time and motion study and informed branch managers how many members of staff they should have based on the quantity and type of items they dispensed.

The usual process for booking annual leave was to make the request to the branch manager in advance and cover would be provided by other staff members as required. The current process for staffing was for the branch manager to contact the relief dispenser coordinator and she would provide as many dispensers or pharmacy technicians as the branch manager requested.

The team appeared to work well together during the inspection and were observed helping each other

and moving onto the healthcare counter when there was a queue. The branch manager had also been tasked with improving staff morale and the reputation that the branch has. The staff were very complimentary about the changes and impact that the branch manager has had in a relatively short period of time and spoke about how they had supported him with these changes. The pharmacy staff said that they could raise any concerns or suggestions with the branch manager, their line manager, regional manager or the superintendent's office. Staff were aware of the company whistleblowing policy. The branch manager, supported by dispensers, pharmacy technicians, other branch managers and members of the area team, had worked two evening shifts each week to undertake general housekeeping to support the operational improvements that were required. Some tasks that had been undertaken during these evening shifts included date checking, tidying shelves, organising and archiving paperwork, setting up various folders for document retention and clearing the retrieval system of uncollected prescriptions.

The branch manager was observed making himself available to discuss queries with people and giving advice when he handed out prescriptions. The branch manager did not have any targets in place for professional services due to having other priorities at the moment. He explained that he would use his professional judgement to offer services, such as MURs, when he felt that they were appropriate for the person.

## Principle 3 - Premises ✓ Standards met

### Summary findings

The pharmacy is clean, secure and suitable for the services provided. It has a consultation room to enable it to provide members of the public with access to an area for private and confidential discussions.

### Inspector's evidence

The premises were smart in appearance and appeared to be well maintained. Any maintenance issues were reported to head office. The dispensary was an adequate size for the services provided; an efficient workflow was seen to be in place. Dispensing and checking activities took place on separate areas of the worktops.

There was a private soundproof consultation room which was used by the pharmacist during the inspection. The consultation room was professional in appearance. The door to the consultation room remained locked when not in use. Prepared medicines were held securely within the pharmacy premises and pharmacy medicines were stored behind the medicines counter.

The dispensary was clean and tidy with no slip or trip hazards evident. The pharmacy was cleaned by pharmacy staff. The sinks in the dispensary and staff areas had hot and cold running water, hand towels and hand soap was available. The pharmacy had air conditioning and the temperature was comfortable during the inspection. The lighting was adequate for the services provided.

## Principle 4 - Services ✓ Standards met

### Summary findings

The pharmacy manages its services and supplies medicines safely. It gets its medicines from licensed suppliers, and stores them securely and at the correct temperature, so they are safe to use. People receive advice about their medicines when collecting their prescriptions. And the pharmacy team supports some people who may forget to take their medicines by supplying them in weekly multi-compartment compliance packs.

### Inspector's evidence

The pharmacy had step free access from the pavement and a large car park. A home delivery service was available for people who could not access the pharmacy. The services provided by the pharmacy were advertised and health promotion leaflets were available. Pharmacy staff referred people to other local services using local knowledge and the internet to support signposting. The branch manager had discussed with the local surgery how to arrange alternative prescriptions for medicines that were unavailable and 'flu vaccinations.

A dispensing audit trail was in place through the practice of staff signing their initials on the dispensed and checked by boxes on medicine labels. Dispensing baskets were used to keep medication separate. Different coloured baskets were used to prioritise workload.

Medicines were supplied in multi-compartmental compliance packs for some people. The process had been reviewed by a pharmacy technician so ensure that it could be followed by any dispenser working at the branch. The system had been updated and a tracking sheet was used each week so that it was clear that prescriptions had been ordered, received, dispensed and supplied. Prescriptions were ordered in advance to allow for any missing items to be queried with the surgery ahead of the intended date of supply. Each patient had a record sheet showing the dosage time and which external items they required. A sample of dispensed compliance packs were seen to have been labelled with descriptions of medication and an audit trail for who had been involved in the dispensing and checking process. Patient information leaflets (PILs) were included with each monthly supply. A Community Monitored Dosage System Suitability Assessment was available on the intranet, but it was unclear whether it had been used for people that already used the service.

The repeat prescription service had been reviewed by the branch manager and people were now required to order their own repeat prescriptions to reduce medicine waste. The company used a hub and spoke model for dispensing repeat prescriptions and the hub was called Central Fulfilment (CF). All prescription were labelled at the pharmacy and as part of the process they were identified as being suitable to be sent for CF. The pharmacist completed an accuracy check and clinical check on the computer system before releasing the labelling information for CF. Dispensed medicines were then returned in barcoded bags to be reconciled with the prescription form and put into the retrieval system. The branch manager was planning to start using a text message system to inform people that their prescriptions were ready to collect. There was a contingency process for people that came to collect their prescription before it had been received from CF and for medicines out of stock at CF. The branch manager audited three prescriptions received from CF per day for accuracy and recorded this on a log.

Stickers were attached to completed prescriptions to highlight people suitable for certain services or



that needed fridge or CD items adding. The branch manager was aware of the risks associated with the use of valproate during pregnancy and the need for additional counselling. But he could not locate the educational materials that should be provided to support counselling and agreed to order replacements.

Medicines were obtained from a range of licensed wholesalers and a specials manufacturer. Medicines were stored in an organised manner on the dispensary shelves. All medicines were stored in their original packaging. Split liquid medicines were marked with the date of opening. Date checking should have been carried out in accordance with a plan issued by head office, but this had fallen behind due to the staffing problems. Various parts of the dispensary had recently been date checked and the branch manager knew which areas had not been. So, the team was taking extra care to check expiry dates during dispensing. Out of date eye drops were found present in a drawer, but the manager knew this area had not been date checked and that it was likely there would be out of date stock. After work date checking was planned for later in the week to complete the remaining sections.

The pharmacy was not yet compliant with the Falsified Medicines Directive (FMD) and head office were trialling the system in other branches before it was implemented across the company. Patient returned medicines were stored separately from stock medicines in designated bins. The pharmacy was informed of drug recalls via alerts from head office and NHS England. A record of recalls was kept and recalls were annotated and signed as evidence.

The CD cabinets were secure and a suitable size for the amount of stock held. Medicines were stored in an organised manner inside. Secure procedures for storing the CD keys during the day were in place. Substance misuse prescriptions were dispensed in advance of the patient coming to collect them. This reduced work load pressure and the risk of dispensing incorrect doses when the patient came to collect the prescription. Assembled substance misuse prescriptions were stored in the CD cabinet. There was a medical fridge used to hold stock and assembled medicines. The medicines in the fridge were stored in an organised manner. Fridge temperature records were maintained, and records showed that the pharmacy fridge was working within the required temperature range of 2°C and 8°Celsius.

## Principle 5 - Equipment and facilities ✓ Standards met

### Summary findings

The pharmacy has the equipment it needs to provide services safely. And the pharmacy team uses it in a way that keeps people's information safe.

### Inspector's evidence

The pharmacy had a range of up to date reference sources, including the BNF and the children's BNF. Internet access was available. Patient records were stored electronically and there were enough terminals for the workload currently undertaken. A range of clean, crown stamped measures were available. Separate measures were available for preparation of methadone. Counting triangles were available and there was a separate, marked triangle used for cytotoxic medicines. Screens were not visible to the public as members of the public were excluded from the dispensary. Cordless telephones were in use and staff were observed taking phone calls in the back part of the dispensary to prevent people using the pharmacy from overhearing.

### 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.