General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Weldricks Pharmacy, 48a High Street, Royston, BARNSLEY, South Yorkshire, S71 4RF

Pharmacy reference: 1039094

Type of pharmacy: Community

Date of inspection: 02/09/2024

Pharmacy context

The pharmacy is adjacent to a GP surgery in Royston, near Barnsley. Pharmacy team members dispense NHS prescriptions and sell a range of over-the-counter medicines. The pharmacy provides services, such as the NHS Pharmacy First service. And team members deliver medicines to people's homes when required.

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 adequately identifies and manages risks. It has the written procedures it needs relevant to help team members provide services safely. Pharmacy team members understand their role to help protect vulnerable people. And they suitably protect people's confidential information. Team members discuss the mistakes they make so that they can learn from them. But they don't always record these mistakes. So, they may miss some opportunities to learn and improve.

Inspector's evidence

The pharmacy had a set of standard operating procedures (SOPs) in place electronically to help pharmacy team members manage risks. The superintendent pharmacist (SI) reviewed the SOPs on a rolling cycle. And the electronic system recorded that team members had read and understood the SOPs.

Team members had discussed and mitigated some risks of providing the NHS Pharmacy First service to people. These included making sure that team members were properly trained to provide the service. And making sure the pharmacy had the necessary equipment and medicines in place. The pharmacy's head office had completed general risk assessments to help team members manage the risks of providing services. Team members explained there was an assessment that included providing NHS services. But this could not be found during the inspection. They also explained that they did not usually have an opportunity to add to the head office risk assessment. This meant they may not have the opportunity to add risks that were only relevant to their pharmacy. Or to add or change risks that emerged as they provided the service.

The pharmacist highlighted mistakes identified before people received their medicines, known as near misses. There were documented procedures to help them do this effectively. They used an electronic system to record the information. But team members admitted that due to current staffing pressures, not all mistakes were being recorded. The pharmacist discussed mistakes with the team member involved. They discussed specific information about why the mistakes had been made. And the changes they could make to prevent a recurrence. But this information was not usually recorded to help aid future reflection and learning. The data collected was analysed each month by colleagues at head office, to help establish patterns of mistakes. And team members were provided with a monthly patient safety bulletin about common mistakes happening across the company. And steps they could take to help prevent a similar mistake happening again. The pharmacy recorded dispensing errors, which were errors identified after the person had received their medicines. The records available gave a clear explanation of the error. And documented information about identified causes, to help inform the most appropriate changes.

The pharmacy had a documented procedure for handling complaints and feedback from people. But the process was not advertised to people in the pharmacy's retail area. Team members explained people usually provided feedback verbally and by leaving reviews online. There were no recent examples of any changes the team had made in response to people's feedback.

The pharmacy had current professional indemnity insurance. It kept accurate controlled drug (CD) registers electronically, with running balances in all registers. Pharmacy team members audited these

registers against the physical stock quantity at least every month. The pharmacy maintained a register of CDs returned by people for destruction, and this was correctly completed. It maintained a responsible pharmacist (RP) record. But the record often had gaps in the sign-out time of the RP. The pharmacist displayed their responsible pharmacist notice so they could be identified. Pharmacy team members monitored and recorded fridge temperatures daily. And they accurately recorded private prescriptions and emergency supplies.

The pharmacy kept sensitive information and materials in restricted areas. It collected confidential waste in dedicated bags. The bags were sealed when full and collected approximately monthly by a waste disposal contractor for secure destruction. The pharmacy had a documented procedure in place to help pharmacy team members manage sensitive information. Team members explained how important it was to protect people's privacy and how they would protect confidentiality. And they completed information governance and security training each year.

Pharmacy team members explained how they would raise their concerns about vulnerable children and adults. And how they would discuss their concerns with the pharmacist and other colleagues. Team members were also aware of how to find information about key local safeguarding contacts by using the internet. The pharmacy had a documented procedure to help team members manage a safeguarding concern. Team members completed formal safeguarding training every year.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has team members who are qualified for their roles and the services they provide. Pharmacy team members regularly complete ongoing training to help keep their knowledge and skills up to date. But the pharmacy does not currently have a manager. So, team members may not always have the right leadership to help define their responsibilities and priorities. Pharmacy team members feel comfortable making suggestions to improve the pharmacy's services.

Inspector's evidence

At the time of the inspection, the pharmacy team members present were a locum pharmacist, three qualified dispensers who worked part-time, and a part-time medicines counter assistant. Also present was a relief dispenser and the pharmacy's area manager. Both were qualified dispensers and were at the pharmacy to help dispense prescriptions. Team members were generally managing the dispensing workload, but they were not always completing some key processes, such as keeping up to date with dispensing repeat prescriptions and recording their mistakes. The pharmacy was operating using various locum pharmacists. Pharmacy team members explained they had not had a regular pharmacist since May 2024. Or a pharmacy manager since June 2024. And this had caused some issues with lack of effective leadership in the pharmacy and keeping up with the workload. The area manager explained the support that was being provided to the pharmacy while they recruited new team members. A new non-pharmacist manager had been appointed and was currently completing their induction training. In the meantime, support was being provided by a manager from another local branch.

Pharmacy team members completed mandatory e-learning modules regularly. These focussed on training such as information governance and safeguarding. But also covered information relevant to the pharmacy's services. Some recent examples were training to support NHS Pharmacy First service and learning about infection control. Team members also regularly discussed learning topics informally with each other. The pharmacy had an appraisal process for pharmacy team members. They had a meeting every year with their manager to discuss their performance. And they set objectives to address any learning needs identified.

Team members explained how they would raise professional concerns with the area manager or head office colleagues if necessary. They felt comfortable raising concerns and making suggestions to help improve the pharmacy's ways of working. They were confident that their concerns and suggestions would be considered, and changes would be made where they were needed. And explained how they could easily request support to cover planned and unplanned absences. The pharmacy had a whistleblowing policy, but pharmacy team members did not know how to access the process. They were aware of other organisations where they could raise concerns, such as GPhC and NHS England.

Team members communicated openly during the inspection. The explained how they felt comfortable discussing ideas with each other to help improve the way they worked. One recent example had been introducing a rota to help define who was responsible for certain tasks during the day. This had helped the team be clear about which tasks they needed to complete. And which tasks would be completed by another colleague.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is generally clean and properly maintained. It provides a suitable space for the services provided. Team members adequately use the space to manage people's privacy. But they could sometimes use the available space more effectively.

Inspector's evidence

The pharmacy was generally clean and sufficiently maintained. Most areas of the pharmacy were tidy and well organised. But there was a limited amount of bench space available to work from. And there were several areas of the benches that were cluttered with items such as dispensing baskets, stock, and paperwork. This reduced the amount of bench space available to work from. And increased the risks of making mistakes. The pharmacy's floors and passageways were generally free from clutter and obstruction. It kept equipment and stock on shelves throughout the premises. The pharmacy had a private consultation room. Pharmacy team members used the room to have private conversations with people.

The pharmacy had a clean, well-maintained sink in the dispensary used for medicines preparation. It had a toilet, with a sink which provided hot and cold running water and other facilities for hand washing. The pharmacy maintained its heating and lighting to acceptable levels. The pharmacy's overall appearance was professional, including the pharmacy's exterior which portrayed a healthcare setting. The pharmacy's professional areas were well defined by the layout and were signposted from the retail area. Pharmacy team members prevented access to the restricted areas of the pharmacy.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy’s services are accessible to people. It has systems in place to help it provide services safely and effectively. And team members provide people with advice and information about higher-risk medicines. The pharmacy sources its medicines appropriately. And it generally stores and manages its medicines as it should. But the pharmacy could store some of its medicines more effectively to help reduce the risks of mistakes.

Inspector's evidence

The pharmacy had ramped access from the street through an automatic door. Pharmacy team members could use the electronic patient medication record (PMR) system to produce large-print labels to help people with visual impairment take their medicines properly. And they gave examples of how they used written communication to help people with hearing impairment access their services and use their medicines safely.

Pharmacy team members signed the 'dispensed by' and 'checked by' boxes on dispensing labels during dispensing. This maintained an audit trail of the people involved in the dispensing process. They used dispensing baskets throughout the dispensing process to help prevent prescriptions being mixed up. The pharmacy occasionally delivered some medicines to people in an emergency. It recorded the deliveries it made. The delivery driver left a card through the letterbox if someone was not at home when they attempted delivery. The card asked people to contact the pharmacy.

The pharmacist counselled people receiving prescriptions for valproate if appropriate. And they checked if the person was aware of the risks if they became pregnant while taking the medicine. They also checked if the person was on a Pregnancy Prevention Programme. The pharmacy had printed materials available to provide to people to help them manage the risks of taking valproate. Team members were aware of the requirements to dispense valproate in manufacturer’s original packs.

Some areas of the pharmacy’s shelves where medicines were stored were cluttered and untidy. This included the fridge, which was also very full. The medicines stored on the dispensary shelves were disorganised and there were several examples of look-alike and sound-alike medicines and different strengths of the same medicine being stored together in the same stack of boxes, which increased the risk of team members selecting the wrong medicine or strength when dispensing. This was discussed, and team members explained that the shelves were usually tidier and more organised. But recent staffing pressures had prevented them from organising the shelves as they would normally. They gave their assurances that they were working hard, with support from head office, to catch up with the workload and provide time to tidy properly. And to reduce their current stock holding to help reduce clutter. The pharmacy stored controlled drugs (CDs) in a locked CD cabinet.

The pharmacy obtained medicines from licensed wholesalers. It had disposal facilities available for unwanted medicines, including CDs. Team members monitored the minimum and maximum temperatures in the pharmacy’s fridge each day. And current records were available. Pharmacy team members checked medicine expiry dates every three months, and they recorded their checks. They highlighted medicines due to expire in the next six months. And these items were removed from the shelves during the month before their expiry. Pharmacy team members explained how they acted when

they received a drug alert or manufacturers recall. And they recorded these actions.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the necessary equipment available to provide its services, which it properly maintains. And the team manages and uses the equipment in ways that protect people’s confidentiality.

Inspector's evidence

The pharmacy had the equipment it needed to provide the services it offered. The resources it had available included the British National Formulary (BNF), the BNF for Children, various pharmacy reference texts and use of the internet. It kept its computer terminals in the secure areas of the pharmacy, away from public view, and these were password protected. And bags of medicines waiting to be collected were kept in the secure areas of the pharmacy, away from public view, so people's private information was protected. The pharmacy restricted access to its equipment. It had a set of clean, well-maintained measures available for liquid medicines preparation.

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.