General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Well, High Street, Bentley, DONCASTER, South Yorkshire, DN5 0AP

Pharmacy reference: 1039153

Type of pharmacy: Community

Date of inspection: 22/08/2019

Pharmacy context

This community pharmacy is on the main shopping street of a residential suburb on the outskirts of Doncaster, South Yorkshire. The pharmacy sells over-the-counter medicines and dispenses NHS and private prescriptions. It offers advice on the management of minor illnesses and long-term conditions. It supplies medicines in multi-compartmental compliance packs, designed to help people remember to take their medicines. 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 met	N/A	N/A	N/A
2. Staff	Standards not all met	2.1	Standard not met	The pharmacy does not have the necessary staffing contingency plans in place to support its team through periods of unplanned absences. This had led to key tasks in the pharmacy falling behind schedule and pharmacy team members being put under increased pressure.
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 has up-to-date procedures to support its team in delivering services. It responds appropriately to people who raise concerns and provide feedback about its services. And it keeps people's personal information safe and secure. Pharmacy team members have the necessary knowledge to recognise and report concerns to protect the welfare of vulnerable people. They act to learn from their own mistakes by engaging in discussions about the safety of the pharmacy's services. But the pharmacy doesn't regularly record the outcomes of these discussions to help review the effectiveness of any actions taken. The pharmacy generally keeps all records it must by law. But it does not always make records associated with the receipt and supply of some of its medicines in the required timeframe. This could make it harder for the pharmacy to investigate any discrepancies.

Inspector's evidence

The pharmacy had a set of up to date standard operating procedures (SOPs). These included responsible pharmacist (RP) requirements, controlled drug (CD) management, dispensary processes and services. The superintendent pharmacist's team reviewed the SOPs on a rolling two-year cycle. The SOPs set out the roles and responsibilities of staff. And training records for the team on duty confirmed staff had read and understood SOPs relevant to their role. A member of the team explained what tasks could and couldn't be completed if the RP took absence from the premises. The pharmacy's accuracy checking technician (ACT) demonstrated how pharmacists physically recorded details of their clinical check. This helped to inform her professional judgement when carrying out the accuracy check of medicines. Pharmacy technicians worked well within their extended roles and were confident in managing queries and concerns directly with surgery teams. They recognised when there was a need to refer to the pharmacist for support and information.

Work benches at the front of the dispensary were cluttered and baskets of medicines waiting to be accuracy checked were stacked. But these did not risk falling over. The pharmacy team had left some baskets with prescriptions inside on the dispensary floor. The RP explained these were prescriptions relating to the pharmacy's 'Free repeat prescription service' (FRPS). They were waiting to be labelled, picked and assembled. The pharmacy had annotated the date these prescriptions were due for collection on each basket to help the team manage workload. The pharmacy team completed high-risk tasks such as assembling multi-compartmental compliance packs in the back area of the dispensary. This effectively reduced the risk of interruptions during the dispensing process.

The pharmacy had a MethaMeasure machine to help manage the dispensing of methadone. Profiles on the machine contained up-to-date photographs of the person accessing the service. And pharmacy team members were observed confirming people's identity prior to supervising consumption of methadone. The pharmacy had systems in place for inputting data from prescription forms into the system. And pharmacists managed the clinical and accuracy checks associated with the service.

Pharmacy team members took ownership of their mistakes by discussing them with the pharmacist at the time they occurred. A near-miss error log was kept electronically. Despite some recent pressures on the team caused by low staffing levels, near-miss error rates had not fluctuated significantly. Pharmacy team members confirmed this could have been down to staff being busy and not always having the

time to enter a near-miss error. They explained how all pharmacy dispensing incidents would be reported on the system as a matter of priority. And incident reporting rates had increased recently. The pharmacy's computer system provided a trend-analysis of the types of mistakes made. And pharmacy team members explained the manager discussed these with them as part of a monthly patient safety review. But pharmacy team members were not aware of any written records of these discussions or of the actions discussed to help reduce the risk of a similar mistake occurring. Pharmacy team members could demonstrate some of these actions. For example, white boxes were used to separate similar sounding medicines. And the pharmacy had annotated these with warning labels to help prompt additional checks during the picking process.

The pharmacy had a complaints procedure in place. And it provided details of how people could leave feedback or raise a concern about the pharmacy through a notice in the public area. A member of the team explained how she would manage a complaint and understood how to escalate concerns if required. Pharmacy team members expressed that feedback about waiting times and prescriptions not being ready on time had risen during the last few months. But they were not aware of any formal concerns raised about the matter. Pharmacy team members explained how they were working hard to manage waiting times and to provide realistic waiting times during busier periods. This helped to meet people's expectations.

The pharmacy had up to date indemnity insurance arrangements in place. The RP notice contained the correct details of the RP on duty. Entries in the responsible pharmacist record generally complied with legal requirements. One missed sign out time from 16 August 2019 was noted. The pharmacy's Prescription Only Medicine (POM) register was kept in accordance with legal requirements. The pharmacy retained completed certificates of conformity for unlicensed medicines with full audit trails completed to show who unlicensed medicines had been supplied to.

The sample of the controlled drug (CD) register examined was not compliant with legal requirements as several entries had been missed. The pharmacy maintained running balances. These had last been checked against physical stock on 25 July 2019. The pharmacy had carried out weekly stock checks prior to this. The balance discrepancies found during the inspection prompted a full balance check of all CDs against physical stock on the day of inspection. Discrepancies found were identified as missed entries and rectified. A discussion took place about the need to ensure all entries in the register were carried out at the time or at the very latest within a day of supply or receipt of a CD. The pharmacy maintained a CD destruction register for patient returned medicines. And the team entered returns in the register on the date of receipt.

The pharmacy displayed a privacy notice. All pharmacy team members completed mandatory information governance training. Pharmacy team members demonstrated how their working processes kept people's information safe and secure. And all person identifiable information was stored in staff only areas of the pharmacy. The pharmacy had submitted its annual NHS information governance toolkit. It disposed of confidential waste by using shred-it bins and white shred-it sacks. The waste was collected for secure disposal periodically.

The pharmacy had procedures and information relating to safeguarding vulnerable people in place. Pharmacy team members had completed e-learning on the subject. Pharmacists, the ACT and pharmacy technicians had completed level two safeguarding training. Pharmacy team members could explain how they would recognise and report a safeguarding concern. And had access to contact information for local safeguarding teams. Pharmacy team members identified how concerns relating to people's health deteriorating or concerns about medicines not being taken correctly were shared with surgery teams.

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

Summary findings

Although the pharmacy employs enough skilled and knowledgeable people to provide its services, it does not have the necessary staffing contingency plans in place to support its team through periods of unplanned absences. This had led to key tasks in the pharmacy falling behind schedule and pharmacy team members being put under increased pressure. Pharmacy team members engage in regular conversations relating to risk management and safety. But they do not record the outcome of these conversations to prompt shared learning. The pharmacy promotes how its team members can provide feedback. And it listens to safety concerns and acts on these appropriately. But the team's current concerns about workload pressures have not been escalated appropriately. The pharmacy has some systems in place for supporting the learning needs of its team members through ongoing training and structured feedback.

Inspector's evidence

On duty at the time of inspection was the RP (a locum pharmacist), a qualified dispenser (pharmacy assistant), two pharmacy technicians, an ACT and the delivery driver. The pharmacy also employed the pharmacist manager and four other members of support staff. The pharmacy had suffered from some acute staffing absences. This was due to three of its team members requiring unplanned sickness leave within recent months. One member of the team was still on leave and another was on phased return at the time of inspection. A pharmacy technician was due to leave the business within the next week and another pharmacy technician was due to go on annual leave. The pharmacy team was not aware of any plans to replace the pharmacy technician leaving the business. All pharmacy support staff on duty expressed they felt under pressure by the current situation. Some members of the team reported having to work more than their normal hours to help support service delivery and explained how this was impacting on their personal lives.

Pharmacy team members explained they had raised concerns about keeping up to date with workload during this difficult time. There was no routine support from a relief team. But a person had been sent to the pharmacy to support the team in labelling prescriptions on several occasions when it had expressed concerns. But pharmacy team members explained how this support was not always beneficial as following the prescriptions being labelled they had needed to correct information such as quantities on dispensing labels. This was due to the person labelling being unfamiliar with some pack sizes of medicines stocked by the pharmacy. They expressed this added more time to the dispensing process and increased the risk of a mistake occurring.

Pharmacy team members were focussing on keeping up to date with dispensing tasks. And although busy, workload at the time of inspection was generally up to date. Pharmacy team members did have to inform some people coming into the pharmacy of the need to wait for their prescription being dispensed, despite it being part of the pharmacy's managed workload. Pharmacy team members were observed providing this information in a professional manner and apologising to people for their wait. Other tasks in the pharmacy such as CD balance checks and date checking arrangements had clearly suffered as a result of the staffing situation. The RP explained how the pharmacy was due to implement a new clinical computer system and off-site dispensing in October 2019. And he felt this would greatly improve workload pressure. A discussion took place about the need to allow time for appropriate

training and implementation of the new system.

Pharmacy team members were encouraged to complete regular learning to support them in their roles. This generally took the form of e-learning modules. They did not receive protected training time during working hours to complete this learning. But confirmed they were able to take time during quiet periods if needed when the pharmacy was fully staffed. The pharmacy did have a structured appraisal system. This allowed its team members to review their learning and development needs at regular intervals with their manager.

The pharmacy team members were friendly and engaged people in conversation. The manager discussed progress towards the pharmacy's targets with the team. This encouraged team members to support pharmacists by identifying people who may benefit from services such as Medicine Use Reviews (MURs) and the New Medicines Service (NMS). The RP on duty explained he was not set targets when working at the pharmacy and expressed how he enjoyed providing services and engaging with people about their health and wellbeing. He explained how he applied his professional judgement. For example, during busy times he would prioritise the efficiency of the dispensing service over advanced services.

The pharmacy team shared information through informal discussions and team briefings. Pharmacy team members identified actions they had implemented to help reduce risk to dispensing processes following these conversations. But the pharmacy didn't regularly document learning points and feedback relating to these patient safety discussions to help prompt shared learning with members of the team not on duty.

The pharmacy had a whistleblowing policy in place. Pharmacy team members confirmed their awareness of how to raise concerns or provide feedback about the pharmacy. And they did confirm that they felt safety concerns would be addressed appropriately. A pharmacy team member provided an example of a historic safety concern which the company had acted upon to resolve. Pharmacy team members were invited to complete a staff survey. But results from the most recent survey were not yet available to the team.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean, secure and maintained to the standards required. 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 clean and secure. Work benches at the front of the dispensary were cluttered at the beginning of the inspection. This left the person labelling and assembling prescriptions with a small space to complete acute workload. The pharmacist had protected space for carrying out the final accuracy check of medicines. And there was a good amount of space provided for completing tasks associated with the multi-compartmental compliance pack service, including the final accuracy check of these packs. The team used some floor space at the front of the dispensary to hold prescriptions in baskets and bags of appliances. Although not ideal, the team pushed these items against shelving to reduce any risk of trip or fall. Off the back of the dispensary was a store room. Part of the room was fitted out to provide space for additional dispensary tasks such as accuracy checking multi-compartmental compliance packs. Staff facilities led off the store room.

The premises were maintained to a respectable standard. Pharmacy team members reported maintenance and IT issues to a dedicated support desk. The pharmacy had heating, and lighting was sufficient. A portable air conditioning unit was in use in the dispensary to help control the temperature during summer months. Antibacterial soap and paper towels were available close designate hand washing sinks. Pharmacy team members used the dispensary sink primarily for washing equipment and reconstituting liquid medicines.

The pharmacy had a sign-posted consultation room. This was relatively clean and organised. It offered a suitable space for holding confidential conversations with people. The RP was observed using the room throughout the inspection with people accessing some of the pharmacy’s services.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy advertises its services. And it works well to promote the role of community pharmacy. It has up-to-date procedures to support the pharmacy team in delivering its services. And people visiting the pharmacy receive support and information to help them take their medicine safely. The pharmacy obtains its medicines from reputable sources. But pharmacy team members are struggling to keep up-to-date with some processes involved in storing and monitoring medicines. This could increase the risk of a mistake occurring during the dispensing process.

Inspector's evidence

The pharmacy had step-free access through a power assisted door. It advertised details of its opening times and services clearly. The pharmacy had a small health promotion zone close to its designated waiting area. And it provided seating in this area for people waiting for prescriptions or services. The pharmacy's consultation room was fitted with a hearing loop and its public area was accessible to people using wheelchairs and pushchairs. Pharmacy team members used their own local knowledge and information available on the internet to help signpost people to other healthcare organisations when required.

Pharmacy team members assisted in identifying eligible people for services during the dispensing process. And the RP confirmed he had the opportunity to provide services and counselling to people when working at the pharmacy. The pharmacy manager had undertaken some flu vaccinations offsite for a business during the 2018/2019 flu season. This helped to promote the role of community pharmacy well.

The pharmacy team was aware of the risks associated with the supply of high-risk medicines such as warfarin, lithium, methotrexate, valproate and insulin. They demonstrated how they identified prescriptions for medicines using stickers. The RP confirmed he carried out verbal counselling and monitoring checks with people on these medicines. And he was aware of the requirement to supply a valproate pregnancy prevention programme (PPP) warning card when dispensing valproate preparations to people in the high-risk group.

The pharmacy used coloured baskets throughout the dispensing process. This kept medicines with the correct prescription form and helped inform workload priority. Pharmacy team members signed the 'dispensed by' and 'checked by' boxes on medicine labels to form a dispensing audit trail. The pharmacy team kept original prescriptions for medicines owing to people. The team used the prescription throughout the dispensing process when the medicine was later supplied. It maintained a full audit trail for prescriptions it ordered through FRPS. The pharmacy was trialling a system of using an audit trail from the clinical software system to order these prescriptions at the time of inspection. A pharmacy team member explained this had been implemented to support the team in managing the service, as the paper-based audit trail previously in place had been having an impact on task management. People receiving their medicines through the pharmacy's delivery service were asked to sign for receipt of their medicine.

Several members of the team assisted in the preparation of multi-compartmental compliance packs.

The pharmacy used individual profile sheets for each person on the service. And it tracked changes associated with people's medication record within these profiles. A sample of assembled packs found that the pharmacy did not always physically attach backing sheets to packs. The ACT confirmed she routinely attached backing sheets, but the RP confirmed he did not. A discussion took place about the risk of backing sheets becoming detached from packs if they were not properly secured. The pharmacy provided a description of the medicines inside packs to help people identify them. Pharmacy team members completed full dispensing audit trails by signing packs and they provided patient information leaflets at the beginning of each four-week cycle of packs.

The pharmacy sourced medicines from licensed wholesalers and specials manufacturers. Pharmacy team members understood the requirements of the Falsified Medicines Directive (FMD) and demonstrated changes to medicine packaging such as the tamper proof seals. The team was aware that the new computer system was designed to assist them in complying with FMD requirements. Training material and information about the new system and how it would help support compliance was available through E-Expert modules. Pharmacy team members explained they would access this material before the new system was installed.

The pharmacy stored Pharmacy medicines behind the medicine counter. This meant the RP had supervision of sales taking place and was able to intervene if necessary. The pharmacy stored medicines on the dispensary shelves in an organised manner. The pharmacy had a date checking matrix in place which prompted rolling monthly checks across a quarterly schedule. But pharmacy team members had struggled to keep up-to-date with these tasks. Many tasks from May and June remained not started. But the team had recognised it had fallen behind and had made active efforts to complete all tasks for July. Pharmacy team members had yet to start any tasks for August. This meant that stock not checked in May could be missed again if August's tasks remained incomplete. Both the RP and ACT vigilantly checked expiry dates as part of their accuracy checking process. Several out-of-date medicines were found during random checks of dispensary stock. These were removed and bought to the attention of team members. Some short-dated medicines were identified. And the team annotated details of opening dates on bottles of liquid medicines.

The pharmacy held CDs in secure cabinets. Medicine storage inside the cabinets was orderly. There was designated space for storing patient returns, and out-of-date CDs. An out-of-date box of buprenorphine sublingual tablets was found amongst current stock. It was segregated immediately to prevent any risk of it being dispensed. Pharmacy team members could explain the validity requirements of a CD prescription and demonstrated how CD prescriptions were highlighted to prompt additional checks during the dispensing process.

The pharmacy had two fridges for storing cold chain medicines. Medicines inside the larger fridge were stored in an organised manner. But the second fridge was at maximum capacity. And stock inside was disorganised with multiple medicines stored randomly together. This meant there could be an increased risk of a picking error during the dispensing process and it could cause inconsistent air-flow between items in the fridge. The pharmacy used clear bags to store assembled cold chain medicines. This prompted additional checks of high-risk medicines such as insulin prior to hand-out. The pharmacy team checked the fridge temperatures daily and recorded, minimum, current and maximum temperatures. Recent temperature records indicated the fridges were operating between two and eight degrees Celsius as required.

The pharmacy has medical waste bins and CD denaturing kits available to support the team in managing pharmaceutical waste. A pharmacy technician demonstrated how the pharmacy received drug alerts through the company intranet. And explained the processes in place for checking alerts. All alerts were

actioned to date.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs for providing its services. And it applies routine monitoring checks to ensure equipment remains safe to use. Pharmacy team members manage and use equipment in ways which protect 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 company intranet and the internet provided the team with further information. Computers were password protected and information on computer monitors was protected from unauthorised view due to the layout of the premises. Pharmacy team members on duty had working NHS smart cards. The pharmacy stored assembled bags of medicines on allocated shelving to the side of the dispensary. This protected people's private information against unauthorised view. Pharmacy team members used cordless telephone handsets when speaking to people over the telephone. This meant they could move to a private area of the pharmacy when having confidential conversations with people over the telephone.

Clean, crown stamped measuring cylinders were in place for measuring liquid medicines. And included separate identifiable cylinders for measuring methadone. The pharmacy had clean counting equipment for tablets and capsules. This included a counting machine which was clean and regularly checked to ensure it was counting accurately. Pharmacy team members calibrated the MethaMeasure machine against three measurements each day. They regularly completed cleaning and routine maintenance checks of the machine to ensure it was kept in working order. The machine was covered by a support contract. And pharmacy team members confirmed any matters arising where dealt with efficiently. Electrical equipment was subject to periodic safety checks. Portable appliance testing had been completed within the last few weeks.

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.