General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Weldricks Pharmacy, 122 Thorne Road, Edenthorpe, DONCASTER, South Yorkshire, DN3 2JA

Pharmacy reference: 1039178

Type of pharmacy: Community

Date of inspection: 14/03/2024

Pharmacy context

The pharmacy is on a main road in the village of Edenthorpe, close to Doncaster in South Yorkshire. Its main services are dispensing prescriptions and selling over-the-counter medicines. The pharmacy provides support and advice to people with minor ailments through the NHS England Pharmacy First Service. It provides a range of other NHS services including seasonal vaccination services and free blood pressure checks for people through the NHS Hypertension Case-Findings 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	1.8	Good practice	Pharmacy team members are confident in identifying and recording the actions they take to help keep vulnerable people safe from harm.
2. Staff	Standards met	2.2	Good practice	The pharmacy demonstrates a continual culture of learning to support its team members in delivering its services safely. It uses a variety of learning approaches to support individual team members learning styles.
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 effectively identifies and manages the risks for the services it provides. It keeps people's confidential information secure, and it mostly keeps the records required by law in good order. The pharmacy prominently advertises the use of a safe space for vulnerable people who may need it. And its team members are vigilant in identifying and reporting concerns to help keep vulnerable people safe from harm. Pharmacy team members respond to feedback they receive about the pharmacy and its services appropriately. And they act openly and honestly by recording and discussing the mistakes they make during the dispensing process.

Inspector's evidence

The pharmacy had a range of standard operating procedures (SOPs) to support its safe and effective running. Its superintendent pharmacist's team reviewed the SOPs on a rolling two-year cycle. And it updated current SOPs and introduced new SOPs as services changed. Team members accessed the SOPs electronically and they completed regular learning to ensure they were up to date and understood the contents of the SOPs. Team members on duty were confident working in their roles and they referred to the responsible pharmacist (RP) for support when needed. A team member discussed what tasks they would not complete if the RP took absence from the pharmacy.

The pharmacy had processes for managing mistakes made and identified during the dispensing process, known as near misses. It operated a no blame culture, and this was reinforced through a culture of referring to near misses as good catches and through processes designed to support an open and honest reporting culture. Pharmacy team members reviewed their work following the RP identifying a mistake. This helped them to find the mistake they had made and to rectify it. Team members generally recorded the near misses they made. But they explained that some locum pharmacists did not always take the opportunity to feed back to them following a near miss, despite them asking for this feedback. And they recognised this could be a barrier to reporting near misses. The pharmacy had processes for reporting and learning from mistakes identified following the supply of a medicine to a person, known as dispensing incidents. Incident reports identified the root cause of a mistake and provided details of the actions team members took to reduce risk. For example, reviewing the storage of medicines and separating medicines with similar names, and those that looked alike on the dispensary shelves. The pharmacy had recently experienced a significant increase in dispensing activity following the closure of a nearby pharmacy. The closure had increased workload pressure and as a result the team had not held formal patient safety reviews to show how it was learning from mistakes and managing risk for the last few months. Team members had continued to engage in regular discussions about their mistakes during this time. They demonstrated the actions they took to reduce risk. For example, placing safety prompts on shelf edges in the dispensary to support them in safely storing and picking medicines.

The pharmacy had a complaints procedure. It advertised how people could provide feedback or raise a concern on its website. But it did not advertise this process within the pharmacy. Team members had a clear understanding of how to manage concerns. They had experienced a rise in recent feedback due to increased waiting times for prescriptions. They explained they aimed for local resolution of concerns wherever possible. The team had informed its area manager of the recent rise in feedback. The pharmacy had a safeguarding procedure and information for local safeguarding teams was accessible to

its team members. All team members completed mandatory safeguarding learning; the RP had completed level three learning to support them in their role. Team members regularly took opportunities to speak to vulnerable people. They recorded any concerns they had along with the actions they had taken to report these concerns. For example, sharing concerns with a person's GP. The pharmacy prominently advertised its consultation room as a safe space for people. And team members knew how to support people requiring access to this safe space.

The pharmacy held all personal identifiable information in the staff-only area of the premises and on password protected computers. It separated its confidential waste, and it disposed of this securely. All team members engaged in mandatory learning on data security and confidentiality. The pharmacy had current indemnity insurance. The RP notice displayed had the correct details of the RP on duty. A sample of pharmacy records found them to be mostly in order. One missed sign-out time in the RP record was observed, and very occasionally details of the prescriber recorded in the private prescription register were inaccurate. The pharmacy maintained running balances in its electronic controlled drug (CD) register. Team members completed regular full balance checks of physical stock against the register. And they checked stock levels against running balances within the register upon receipt and upon supply of a CD. Random physical balance checks conducted during the inspection complied with the running balances in the register. The team recorded patient-returned CDs in a separate register at the point of receipt.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy employs a dedicated team of people with the relevant skills and knowledge to provide its services safely. It creates a variety of learning opportunities for its team members, and it tailors this learning to support its team members in fulfilling their roles with confidence. Pharmacy team members know how to provide feedback and raise concerns at work. And they engage in regular discussions to support them in managing risk.

Inspector's evidence

On duty was the RP, who was the regular pharmacist, two trainee pharmacists, and three qualified dispensers. One of the dispensers was the pharmacy manager and had completed specific learning to support them in this role. The pharmacy also employed another qualified dispenser and a trainee pharmacy assistant. Some team members had adjusted their working hours during the company's most recent review of staffing levels. And overall, the pharmacy had been provided with a small number of extra hours to support it in managing the increased volume of dispensing. Team members were behind with dispensing activities. They explained how the current backlog of seven days had reduced from around ten days. The team had checks to ensure people were not left without medicines and it prioritised dispensing for people requiring their medicines urgently.

The pharmacy's trainee pharmacist was working alongside another trainee who was on a short placement from a local hospital to support them in gaining experience of working in a community pharmacy setting as part of their training year. The pharmacy's trainee pharmacist was due to begin a short placement at the hospital as part of this cross-sector learning arrangement. The trainee pharmacist received protected learning time and felt able to feedback about their learning. They had produced a competency assessment to support them and the designated supervisor in tailoring their training needs to specific areas of learning. The trainee pharmacy assistant also received some time at work to complete their learning. All team members engaged in continual learning relevant to their roles. This learning included e-learning, reading newsletters and roleplaying scenarios to ensure team members felt confident when providing pharmacy services. Team members were currently learning to complete blood pressure checks to support the provision of the NHS Hypertension Case-Findings Service. The RP was particularly keen to ensure team members understood the reason behind some of the tasks they carried out. For example, the team had completing learning about side effects and monitoring requirements of some medicines such as warfarin and methotrexate. This helped team members to fully engage and understand the importance of the monitoring checks they were asked to complete with people taking these medicines.

Pharmacy team members worked together well. They engaged in a structured appraisal process to support their learning and development. And they had regular team discussions to share their learning. But they had not taken recent opportunities to record these discussions, they felt this was due to increased workload pressures. The pharmacy had a whistleblowing policy, and its team members knew how to raise a concern at work. Team members felt confident in applying ideas designed to help reduce risk, such as adding prompts to shelf-edges in the dispensary. The pharmacy had some targets for the services it provided. The RP felt able to apply their professional judgment when providing pharmacy services and when making decisions to support people's care needs.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean, secure, and well maintained. It provides a professional environment for delivering its services. People using the pharmacy can speak with a team member in a private consultation room.

Inspector's evidence

The pharmacy was secure from unauthorised access. It was clean and well maintained. Team members knew how to report maintenance concerns and there were no outstanding maintenance issues reported. Lighting was bright and air conditioning provided an ambient temperature in the dispensary and public area. The public area led to the medicine counter which was positioned in front of a part-height wall at the front of the dispensary. The consultation room was professional in appearance. But the position of the door leading into the room made it difficult for people using larger wheelchairs to access the room. And team members explained the room could get warm during summer months. They locked equipment away in the room routinely and could leave the door open to increase air flow into the room when needed. The RP had fed back their ideas on expanding the availability of consultation spaces within the pharmacy to their head office team due to the rise in consultation services.

The dispensary was small, but team members managed the available workspace effectively. There were designated areas for labelling, assembling and accuracy checking medicines. And enough workbench space available to safely dispense medicines. Off the back of the dispensary was a stock room and staff area. This space was kept in an orderly manner and a desk was available in this area to support team members in completing administration tasks. Staff toilet and drink making facilities were provided onsite.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's services are readily accessible to people. It obtains its medicines from reputable sources, and it stores them safely and securely. Dedicated pharmacy team members provide the pharmacy's services safely, They actively review their working processes when introducing new services and as demands for services change. And they engage well with people by providing supportive information to help people manage their health and take their medicines safely.

Inspector's evidence

People accessed the pharmacy at street level, off street parking was provided directly outside. The pharmacy advertised its opening hours, and changes to these for the upcoming bank holidays. It advertised details of its services clearly, including information about the new NHS England Pharmacy First service and the seven conditions the pharmacy could treat through this service. The RP shared information about other healthcare services available locally with team members. This helped to keep team members informed of the most appropriate services to signpost people to if needed. For example, they had obtained contact information for people to refer themselves to a service specialising in minor eye problems. And a team member was observed sharing details of this service with a person when providing advice to them.

The pharmacy was starting to prepare to offer Spring COVID-19 boosters to people. Both the RP and the trainee pharmacist were trained vaccinators. The pharmacy used both the national protocol and patient group direction (PGD) model to support it in delivering vaccination services. This helped to provide some flexibility for how it carried out these services, and supported the RP in managing other services when the vaccination service was running. The RP provided examples of how the team had used learning from the first season of COVID vaccinations to help inform appointment booking schedules for the service in a way which had minimal impact on dispensary workload. And they had used appropriate resources to support their decision making when clinical queries arose through the vaccination service. The RP had immediate access to PGDs and clinical pathways to support them in providing the NHS Pharmacy First service. Their training records were easily accessible and they discussed how they used specific learning to support them in delivering consultation services. The pharmacy was seen to be managing other consultation services such as the NHS New Medicines Service and NHS Hypertension Case-Findings Service effectively, with some positive outcomes for people receiving these services. The pharmacy made appropriate records of the medicines it dispensed through its substance misuse service. It kept signature sheets of the prescribers employed by the substance misuse team. And team members matched signatures to those on the sheets as part of their check when processing a new prescription. The pharmacy had a clear system to support team members in identifying and reporting missed doses of these medicines.

The pharmacy protected Pharmacy (P) medicines from self-selection as it displayed these behind plastic screens on a wall next to the medicine counter. Signs explained to people that staff assistance was required when selecting a medicine from behind the screens. And team members could observe activity in this area from the medicine counter. Team members had a good understanding of the risks associated with some P medicines that were liable to abuse. All P medicines sales were observed to be brought to the direct attention of the RP. And the RP intervened in sales when further information was

required. The pharmacy had robust processes for identifying and managing higher-risk medicines during the dispensing process. This prompted a range of 'therapy checks' involving verbal counselling when they handed medicines out. And team members recorded these interventions on people's medication record (PMR) to support continual care. Team members understood the requirements of the valproate Pregnancy Prevention Programme (PPP), the RP recorded the checks they made to support compliance with the PPP. A split pack of sodium valproate was found on the dispensary shelves. The team found the supply of medicine assembled from the split box had not yet left the pharmacy. A discussion amongst the team highlighted a need to ensure all locum pharmacists were aware of the most recent legal changes to the supply of valproate in original manufacturer's containers. The pharmacy completed assessments with people requiring additional support with taking their medicines. This assessment helped to decide whether the supply of medicines in a multi-compartment compliance pack would be the most suitable way to help them take their medicines correctly. The supply of medicines in compliance packs was mostly made by the company's centralised delivery pharmacy.

The pharmacy used coloured baskets throughout the dispensing process. This kept medicines with the correct prescription form, and it helped the team manage its workload. For example, it used different coloured baskets for different workstreams, such as those for people waiting in the pharmacy. The team recognised current workload pressures. It had taken steps to ask people when they required their medicines. Team members reviewed prescription downloads and separated prescriptions for acute medicines, such as antibiotics and prioritised these for dispensing. Pharmacy team members took ownership of the work they completed by using an assigned dispensing mark in the 'dispensed by' and 'checked by' boxes on medicine labels. They also completed audit trails on prescription forms to support them in identifying who had been involved at each stage of the dispensing process. The pharmacy kept a record sheet of locum signatures to support it in identifying who had been involved in the dispensing of a medicine should a query arise. The pharmacy kept a record of the medicines it owed to people, and team members used the original prescription when dispensing owed medicines. Team members accessed an electronic system to track the delivery of medicines to people through the company's medicine delivery service.

The pharmacy sourced medicines from licensed wholesalers and specials manufacturers. It stored medicines in an orderly manner within their original packaging. It held its CDs in a secure cabinet, and it held medicines requiring cold storage in a medical fridge equipped with a thermometer and data logger. The pharmacy kept temperature records for the fridge which showed it was operating within the required range of two and eight degrees Celsius. Team members completed regular date checking tasks, and they recorded these checks. A random check of dispensary stock found no out-of-date medicines. Team members marked short-dated medicines to help prompt extra checks during the dispensing process. They recorded the opening date on bottles of liquid medicines to support them in ensuring the medicine inside remained safe to supply. And they annotated boxes and bottles of medicines with the batch number and expiry date of the medicine inside when supplying medicines in non-original containers. The pharmacy had appropriate medicine waste receptacles, CD denaturing kits and sharps bins available. It received medicine alerts through email, and it kept an audit trail of the action it took in response to these alerts.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it requires to provide its services. Pharmacy team members use the equipment safely and in a way which protects people's confidentiality.

Inspector's evidence

The pharmacy held assembled bags of medicines waiting for collection on shelves at the front of the stock room. This protected information on bag labels and prescriptions from unauthorised view. Information on the pharmacy's computer monitors faced into the dispensary, and the computer in the consultation room was locked between use. Pharmacy team members used NHS smartcards and passwords when accessing people's medication records. They used a cordless telephone handset. This meant they could move out of earshot of the public area when discussing confidential information over the telephone. They had access to a range of reference resources to support them in obtaining information.

Pharmacy team members used a range of clean counting and measuring equipment for liquids, tablets, and capsules. Separate equipment was available for counting and measuring higher-risk medicines. The pharmacy stored the equipment required for its consultation services safely in the consultation room. It stored its anaphylactic kit in the stock room. And the RP explained this was taken into the consultation room during vaccination clinics. The pharmacy's equipment was from recognised manufacturers. Team members checked the equipment regularly and the pharmacy's electrical equipment was subject to periodic safety checks.

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.