General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Weldricks Pharmacy, Sinclair House, Woodside View; The Crescent, Woodlands, DONCASTER, South Yorkshire, DN6 7JR

Pharmacy reference: 1039181

Type of pharmacy: Community

Date of inspection: 12/02/2020

Pharmacy context

This is a community pharmacy in a village approximately three miles north of Doncaster in 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 some people with their medicines in multi-compartment compliance packs, designed to them to remember to take their medicines. And it provides a medicine delivery service to people's homes.

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
1. Governance	Standards met	1.8	Good practice	Pharmacy team members demonstrate comprehensive knowledge of how to recognise safeguarding concerns. They complete relevant learning associated with safeguarding to keep their skills up to date. And they proactively report concerns to help protect the safety and wellbeing of vulnerable people.
2. Staff	Standards met	2.5	Good practice	The pharmacy team members feel comfortable discussing their ideas for improvement together. And they feel confident raising any professional concerns they may have. The pharmacy actively engages with their feedback to improve workflow and delivery of its services.
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 identifies and manages the risks associated with its services. It keeps people's private information secure. It advertises how people can provide feedback about its services. And displays results from its feedback questionnaires for people to see. The pharmacy generally makes and maintains its records as required by law. The pharmacy has a culture of helping safeguard the welfare of vulnerable people. It supports it team members to recognise and report concerns. And the team members show how reporting their concerns helps to protect vulnerable people. Pharmacy team members act openly and honestly by sharing information when they make mistakes. And they act to reduce risk following these mistakes.

Inspector's evidence

The pharmacy had a set of up-to-date standard operating procedures (SOPs). It held its SOPs electronically on 'Pharmapod'. The SOPs had been reviewed in Autumn 2019 following the appointment of a new superintendent pharmacist. They covered responsible pharmacist (RP) requirements, controlled drug (CD) management, dispensary processes and services. The recent review had considered changes in dispensing processes following the introduction of the Falsified Medicines Directive (FMD). A member of the superintendent's team had prepared the SOPs. And the superintendent pharmacist had provided confirmation to the inspector that they had been authorised by her.

SOPs included the roles and responsibilities of pharmacy team members. And training records associated with the SOPs were available electronically. These records were complete with the exception of one SOP which required completion by one member of the team. Pharmacy team members generally followed SOPs. But there were some circumstances where adherence to dispensary procedures could have been improved. For example, a random sample of assembled items found a small number of dispensing audit trails to be missing from both medication labels and prescription forms.

Team members managed workflow in the dispensary well. There were designated areas of bench space for labelling, assembly and accuracy checks. Baskets containing assembled items waiting to be checked were held on shelves at the back of the dispensary. The team managed tasks associated with the multi-compartment compliance pack service in a separate room, off the back of the dispensary. This room provided a relatively distraction free environment for tasks associated with the service.

Pharmacy team members discussed the near misses they made with the pharmacist. And they generally recorded details of their near misses on a record in the dispensary. Near miss rates were relatively low and pharmacy team members recognised that some opportunities to formally record a near miss during busier periods may be missed. Team members could identify how they discussed their mistakes and applied changes to help reduce risk. For example, they were continually adding to a list of 'look-alike' and 'sound-alike' medicines. And had taken action to separate and highlight some of these medicines on the dispensary shelves. For example, sertraline and sildenafil tablets were separated as were amitriptyline and amlodipine tablets. The pharmacy reported its dispensing incidents electronically through Pharmapod. The reports contained a risk analysis and learning points. Reports were reviewed by the area manager and any additional actions required were highlighted within the reports. Pharmacy

team members discussed learning following an incident and demonstrated how escitalopram and enalapril tablets had been separated on the dispensary shelves following this incident.

The pharmacy's clinical governance lead had changed within the last few months. The role had previously been that of the pharmacist. A dispenser now led on clinical governance and was responsible for collating near miss data and analysing it at the end of the month. The RP confirmed he supported the dispenser in this role by applying his clinical knowledge to the monthly patient safety review process. Key learning points relating to patient safety were shared each month with team members. These included wider learning points from case studies and articles published in pharmaceutical journals. For example, pharmacy team members had shared learning associated with the importance of issuing the medicine spoon or oral syringe which came with liquid medicines, unless no dosing device was provided. The RP explained this was to ensure the correctly calibrated dosing device designed for use with the medicine was supplied. Other examples of risk reduction through wider learning included separating and storing high-risk medicines in baskets on the dispensary shelves. A team member explained how this was useful in promoting additional checks and counselling associated with these medicines.

The pharmacy had a complaints procedure. And it provided details of how people could leave feedback or raise a concern about the pharmacy through its practice leaflet. It also promoted how people could leave feedback through the internet. The pharmacy team checked www.nhs.uk and the Doncaster Healthwatch website daily to check for feedback. The RP explained the pharmacy hadn't received feedback through these channels to date. The team also engaged people in feedback through its annual 'Community Pharmacy Patient Questionnaire'. And it displayed the results of the questionnaire for people to see. The latest results were positive, particularly in regard to staffing and care. A pharmacy team member explained how she would manage feedback and seek to resolve concerns locally in the first instance. Pharmacy team members were aware of how to escalate concerns to a dedicated complaints manager should they need to.

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 complied with legal requirements. The pharmacy held its CD register electronically. A sample of the register examined was compliant with legal requirements. The pharmacy maintained running balances in the register. And full balance checks took place weekly for methadone and monthly for other CDs. Physical balance checks of methylphenidate 5mg tablets and Matrifen 12 microgram/hour patches complied with the balances in the register. The pharmacy maintained a CD destruction register for patient returned medicines. It kept records for private prescriptions and emergency supplies within an electronic Prescription Only Medicine (POM) register. The record generally complied with legal requirements. But the name of the prescriber was occasionally missing from entries for private prescriptions. And not all emergency supplies at the request of a patient were supported with reasons for the supply being made. A sample of the pharmacy's specials records found one incomplete certificate of conformity. This was brought to the attention of the team. Other certificates were kept in accordance with the requirements of the Medicine & Healthcare products Regulatory Agency (MHRA).

The pharmacy displayed a privacy notice. Guidance about how the pharmacy used people's information was available within its practice leaflet. All pharmacy team members had completed mandatory information governance training. The pharmacy had submitted its annual NHS Data Security and Protection toolkit as required. All personal identifiable information was stored in staff only areas of the premises. The pharmacy disposed of confidential waste through securing it in white sacks. These were sealed and sent for secure destruction periodically.

The pharmacy had procedures and a wealth of information relating to safeguarding vulnerable people in place. Contact information for safeguarding teams was accessible. Pharmacy team members had completed e-learning on the subject and the RP and pharmacy technician had completed level two safeguarding training. Pharmacy team members demonstrated sound knowledge of how to recognise and report safeguarding concerns. They provided examples of reporting concerns. And provided evidence of how they had recorded these concerns. Team members had received some support from the pharmacy's management team when needing to report a safeguarding concern.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has suitably skilled and knowledgeable people working to provide its services safely and effectively. Pharmacy team members complete regular learning relevant to their role. And they receive support and time at work to complete this learning. Pharmacy team members engage in regular discussions designed to share learning and ideas. They feel confident raising any professional concerns they may have. And they provide examples of how the pharmacy uses their feedback to improve workflow and delivery of its services.

Inspector's evidence

On duty throughout the inspection was the RP (pharmacy manager), a pharmacy technician and a qualified dispenser. The pharmacy also employed two more qualified dispensers. The team were working with one less team member than usual on the day of inspection due to some unplanned leave. They explained all team members were flexible in supporting cover during periods of leave. And team members were aware they could request some support from the company's relief team if needed. They explained they hadn't needed to do this since the pharmacy had changed ownership some four years ago. A company employed driver provided the pharmacy's prescription collection and medication delivery service.

On the day of inspection pharmacy team members were assembling prescriptions ready for collection the same afternoon. They explained they would normally be a couple of days in front with workload. But several factors including planned and unplanned leave had occurred in the week leading up to the inspection. People visiting the pharmacy during the inspection received their medication in a timely manner. And team members were observed engaging well with people. For example, asking about their health and wellbeing. The pharmacy did have some targets for services such as Medicines Use Reviews (MURs) and New Medicine Service (NMS). The RP explained how he applied his professional judgement when delivering these services. And he received support from all team members in identifying eligible people for these services. A pharmacy team member was observed explaining details of the NMS service to a person and appropriately obtained consent for the service.

Pharmacy team members confirmed they received some learning time during working hours. Some team members preferred to complete continual learning at home. This learning involved e-modules through Mediapharm. Team members also reported reading pharmacy magazines and memos from the superintendent pharmacist's team to help inform their learning. Each member of the team engaged in a structured appraisal process. Pharmacy team members explained the RP was committed to supporting all team members in their continual learning. And often shared his own learning with them.

Pharmacy team members met formally each month for a clinical governance meeting. This meeting focussed on patient safety events and shared learning. Team members explained they would update each other informally throughout the month with information as and when they received it. The pharmacy had a whistleblowing policy in place. And pharmacy team members explained they would address concerns openly amongst each other in the first instance. Most of the pharmacy's team members had worked together for a good number of years. And they showed mutual respect for each other's roles. Team members on duty confirmed they were aware of how to escalate feedback or a

concern about the pharmacy should they need to. They demonstrated some examples of how sharing feedback had led to improvements. For example, they had strengthened the processes for managing the schedule of work associated with the supply of medicines in multi-compartment compliance packs.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean and secure. And the premises provide a professional environment for delivering the pharmacy's services. 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 secure and well maintained. Pharmacy team members reported maintenance concerns directly to the company's premises team. And they reported maintenance issues were dealt with in a timely manner. The pharmacy had suitable heating arrangements. A fan was provided in summer months to help with ventilation. Lighting throughout the premises was sufficient. Cleaning duties were shared amongst team members. On the day of inspection the pharmacy was clean. Antibacterial handwash and towels were available at the dispensary sink. Staff members confirmed they used this sink for hand washing and other tasks such as preparing antibiotic reconstitutions. There was a second designated handwashing sink available to staff. But this was not equipped with antibacterial handwash and team members reported they didn't use the second sink routinely.

The public area was small and open plan. To the side of the public area was the pharmacy's private consultation room. This room offered a suitable environment for holding confidential discussions with people about their medicines. It was appropriately equipped to support the pharmacy's services. The dispensary was through a door behind the medicine counter. It was small. But team members managed the space well. Some items such as wholesaler totes stored on the dispensary floor were pushed back to the edge of the room to avoid the risk of trip or fall. A room off the back of the dispensary provided space for completing administration tasks and tasks associated with the supply of multi-compartment compliance packs. Beyond this room was a staff area and additional storage space.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy promotes its services and makes them accessible to people. It sources its medicines from reputable suppliers. And it manages its medicines safely and securely. The pharmacy identifies high-risk medicines to help make sure people taking these medicines have the support they need. And its team members recognise the benefits of counselling people in the safe use of their medicines. The pharmacy has procedures to support the pharmacy team in delivering its services. But there are some occasions when the team members work outside of these procedures. This means they may not always be working in the safest and most effective way by following agreed processes.

Inspector's evidence

People accessed the pharmacy through a push/pull door up a small step from street level. The pharmacy had a portable ramp available to assist people using wheelchairs or pushchairs with access if required. And team members were observed holding the door open for people on several occasions during the inspection. The pharmacy advertised its opening hours and details of its services. A healthy living promotional display was positioned close to the pharmacy's designated waiting area. Seating was provided in this area.

Pharmacy team members understood the requirement to signpost people to other pharmacies or healthcare services, should the pharmacy be unable to provide a service. For example, people enquiring about the seasonal flu vaccination would normally be signposted to another pharmacy within the village. A pharmacy team member explained how promotion of the company's smart phone application helped people to manage their repeat prescriptions at a time convenient to them. And the team member explained how 19 new sign-ups to the application had taken place over the last week. She went on to explain how this was potentially 19 more people using the application to order their repeat prescriptions rather than ringing the pharmacy. And how this reduced risk during the dispensing process due to less interruptions.

The RP had access to up-to-date patient group directions (PGDs) and a minor ailments protocol to support the supply of medicines through these services. The RP explained how engagement in the NHS Pharmacy Quality Scheme (PQS) audits had resulted in a number of positive outcomes for people. He explained how the audits had prompted reflection of the importance of counselling people about their medicines. And provided some examples of positive outcomes from the audits. For example, recognising a need to add in a proton pump inhibitor when prescribing non-steroidal anti-inflammatory drugs to a person. And identifying some people with diabetes who had not received an annual eye or foot screening appointment. The RP also explained how learning associated with an asthma audit had prompted team members to routinely check if children had a suitable spacer available to support them in using their inhaler.

The pharmacy had robust systems for managing higher risk medicines such as opioids, warfarin, lithium and methotrexate. All team members were trained to identify these medicines and engage in ensuring appropriate monitoring checks were completed. The pharmacy highlighted prescriptions for CDs. This prompted additional checks throughout the dispensing process. The RP demonstrated records associated with the high-risk medicine checks completed by the team. For example, opioid therapy

checks and International Normalised Ratio (INR) monitoring checks. Pharmacy team members were knowledgeable about the requirements of Pregnancy Prevention Programmes (PPP). And could demonstrate how support material, including high-risk warning cards were readily available to issue to people in the high-risk group when supplying valproate preparations.

The pharmacy used tubs and baskets throughout the dispensing process. This kept medicines with the correct prescription form. And it helped to identify workload priority. Pharmacy team members generally signed the 'dispensed by' and 'checked by' boxes on medicine labels to form a dispensing audit trail. The SOP for labelling and assembling medicines also included the completion of a four-way audit grid to help identify who had received the prescription, labelled it, assembled it and accuracy checked it. This was not always completed. The pharmacy team kept original prescriptions for medicines owing to people. The prescription was used throughout the dispensing process when the medicine was later supplied.

The pharmacy had a robust audit trail associated with its managed repeat prescription collection service. A full audit trail of what prescriptions were ordered was maintained. This provided the pharmacy with the opportunity to chase any missing prescriptions and manage queries prior to a person requiring their medicine. People receiving their medicines through the pharmacy's delivery service were asked to sign for receipt of their medicines. Records for the delivery service were retained at the centralised delivery hub. And the pharmacy could request these if required.

The pharmacy had created some simple profile sheets for each person receiving their medicines in multi-compartment compliance packs. But the sheets were not in the company's standardised format. And did not include space for recording information such as dose changes. A pharmacy team member explained how new sheets were created when changes took place. And some changes to medication regimens such as hospital discharge records were held with the profile sheets. The pharmacy team had managed the service through its electronic patient medication record (PMR) system prior to the pharmacy changing ownership around four years ago. Team members explained they had introduced the new sheets following the change of ownership. And they explained they had not been made aware of standardised templates available to support them in managing the service. The pharmacy kept an audit sheet with each profile to confirm who had been involved in dispensing the pack. A sample of assembled packs contained full dispensing audit trails. The pharmacy provided descriptions of medicines inside the packs to help people identify them. And it supplied patient information leaflets with packs at the beginning of each four-week cycle.

The pharmacy sourced medicines from licensed wholesalers and specials manufacturers. Pharmacy team members were knowledgeable about FMD and demonstrated how they had adapted their workflow to ensure compliance. The pharmacy team had raised a concern about only having one scanner available. And the pharmacy's head office had acted on this concern immediately by providing the team with an additional scanner at its second work station. This had improved workflow and reduced the risk of interruption when prescriptions were labelled. The pharmacy completed a small amount of wholesaling to a local surgery through signed orders. This activity required a wholesale dealers license from the MHRA. The pharmacy did not hold this license. A discussion took place about these requirements. And the company did have the ability to fulfil this supply through a number of its other registered pharmacies which held the appropriate license.

The pharmacy stored Pharmacy (P) medicines in cabinets to the side of the healthcare counter. Appropriate signage was displayed indicating to people that assistance was required when selecting medicines from behind the Perspex screens. It stored medicines in the dispensary on shelves in an organised manner. But two medicines were found stored in amber bottles rather than their original

packaging. The labels on these bottles didn't contain all required information such as batch number, expiry date and assembly date of the medicine. The bottles were removed and brought to the attention of the RP. The risks associated with storing medicines in this way was discussed. CDs were held securely in CD cabinets. The stock cabinet was an appropriate size for the amount of stock held. And there was additional room for segregating out-of-date and patient returned CDs securely. The pharmacy held its cold chain medicines in a fridge. Assembled cold chain medicines were held in clear bags. This prompted additional checks prior to the supply of these medicines. The fridge was fitted with a thermometer and a data tracker. Temperature records confirmed cold chain medicines were stored between two and eight degrees Celsius as required.

A date checking rota was in place. This demonstrated regular date checks across all pharmacy stock. And short-dated medicines were clearly highlighted on dispensary shelves. A random check of dispensary stock found no out-of-date medicines. Pharmacy team members annotated bottles of liquid medicines with stickers containing the date of opening. This prompted checks to ensure the medicine remained safe and fit to supply to people.

The pharmacy had medical waste bins and CD denaturing kits available to support the team in managing pharmaceutical waste. It received details of medication recalls and drug alerts electronically. And the team printed these and annotated the alerts with the details of the checks made. Any action taken in response to the alert was also recorded. The pharmacy kept these for reference purposes.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs for providing its services. It monitors it equipment to ensure it remains in safe working order. And pharmacy team members act with care by using the pharmacy's facilities and equipment in a way which protects 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. Pharmacy team members could access additional resources through the internet. The pharmacy's computer system was password protected. And information on computer monitors was protected from unauthorised view through the layout of the premises. Pharmacy team members on duty had working NHS smart cards. The pharmacy stored assembled bags of medicines on shelves in a room off the dispensary. It stored some assembled multi-compartment compliance packs on designated shelves to the side of the dispensary. Details on bag labels in this area could not be read from the public area of the pharmacy. Pharmacy team members used a cordless telephone handset. This meant they could move out of ear-shot of the public area when having confidential telephone conversations.

The pharmacy had a range of crown stamped measuring cylinders for measuring liquid medicines, including separate cylinders for use solely with methadone. The pharmacy had clean counting equipment for tablets and capsules. A set of counting scales were calibrated against the tablets or capsules being counted each time they were used. Stickers on the pharmacy's electrical equipment indicated visual checks of the equipment had been completed in November 2019.

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.