General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Archway Pharmacy, 19-21 Kimberworth Road, ROTHERHAM, South Yorkshire, S61 1AB

Pharmacy reference: 1039222

Type of pharmacy: Community

Date of inspection: 05/02/2024

Pharmacy context

The pharmacy is next to a GP surgery in a residential area of Rotherham. Its main services include dispensing NHS prescriptions, selling over-the-counter medicines and providing advice and support to people with minor ailments. The pharmacy supplies some medicines in multi-compartment compliance packs, designed to help people remember to take their medicines. And it offers a medicine delivery service.

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 not all met	1.6	Standard not met	The pharmacy does not maintain its responsible pharmacist records and the records of the private prescriptions it dispenses accurately. And it cannot show how it keeps its private prescription records for the required retention period.
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 not all met	4.3	Standard not met	The pharmacy does not store all medicines in accordance with legal requirements.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance Standards not all met

Summary findings

The pharmacy does not maintain all records it must by law, and it does not have all records available for inspection as required. Overall, the pharmacy identifies and manages the risks for the services it provides. Pharmacy team members know how to respond to feedback they receive, and they keep people’s confidential information secure. They know how to raise concerns to help protect vulnerable people. And they act openly and honestly to correct mistakes they make when dispensing medicines.

Inspector's evidence

The pharmacy used standard operating procedures (SOPs) to define its working practices. The current SOPs had been personalised for use in the pharmacy using templates provided by its head office. Team members knew how to access the SOPs and those on duty stated they had read them. But not all team members had signed the SOPs to confirm they had understood them. Team members were knowledgeable about their roles and demonstrated how they worked safely when completing tasks. They were observed engaging well with the responsible pharmacist (RP). A team member discussed what tasks could not take place if the RP took absence from the pharmacy.

The team used the functions of its patient medication record (PMR) system to support a series of checks throughout the dispensing process. This relied on barcode technology to complete checks during the assembly process and the final accuracy check of the medicine. The PMR flagged any prescriptions which had not received a clinical check or had not been clinically checked for six months, and those with any changes including new medicines. It also flagged any changes to medicine doses or directions to the RP for a clinical check prior to dispensing activity beginning. The team demonstrated how the PMR flagged mistakes made during the dispensing process, known as near misses. The PMR did not produce dispensing labels until a near miss was rectified. Team members regularly fed back to the PMR developers to inform them of any medicines which could not be scanned. They did this by sending a photograph of the barcode, medicine packaging and where available the quick read (QR) code of the medicine to the developer. Team members felt this helped improve dispensing accuracy as it meant they were able to scan more medicines and reduced the risk of human error during the dispensing process. The team referred any medicines that did not scan to the RP and referred any queries they had during the dispensing process to them. The final accuracy check of these medicines was completed manually by the pharmacist. The team kept a near miss record, one near miss had been recorded since the pharmacy had introduced the current PMR system in August 2023. This mistake had been due to a quantity error. Team members did not routinely record near misses brought to their attention by the PMR system and were not aware if the PMR recorded these. A discussion took place about the advantages of recording near misses at all stages of the dispensing process to help share learning and reduce risk. The pharmacy had a procedure for reporting and investigating mistakes made following the supply of a medicine to a person, known as a dispensing error. The RP explained how they would manage and report a dispensing error through a national reporting tool. They could not recall a dispensing error being brought to their attention in the time they had worked at the pharmacy.

The pharmacy had a complaints procedure. And it advertised how people could provide feedback or raise a concern within its practice leaflet. Its team members knew how to respond to feedback and concerns from people. And they were attentive in establishing people’s needs and expectations. The

pharmacy had a safeguarding procedure and information for local safeguarding teams was accessible to its team members. Pharmacists had completed appropriate safeguarding training and some team members had engaged in learning to support them in recognising and reporting safeguarding concerns. They provided examples of how they had worked collaboratively with other health and social care teams to support vulnerable people in accessing pharmacy services. But not all team members were familiar with code words publicised by national domestic violence safety initiatives, designed to support people in requesting access to a safe space.

The pharmacy held personal identifiable information in the staff-only area of the premises and on password protected computers. Confidential waste was separated from other waste and team members explained this was collected periodically for secure disposal. The pharmacy had current indemnity insurance. The RP notice displayed had the correct details of the RP on duty. But there were regular gaps in the RP record, RPs had not made an entry in the record for four consecutive days in September 2023. And the RP record from the 1 December 2023 to current day showed a further nine missing entries, most of which were from a Saturday. This made it more difficult for the pharmacy to establish who the RP was at any given time if a query arose. Private prescription records available for inspection were incomplete. Only entry numbers 71-83 of the record could be found. And these records did not include the prescriber’s details as required. The controlled drug (CD) register was not always completed in accordance with legal requirements. Some page headers were missing from a sample of records examined and the address of the wholesaler was not recorded when entering receipt of a CD. The pharmacy maintained running balances in the CD register. Pharmacists initialled the register to indicate they were checking the running balance of a medicine when supplying a CD. But full balance audits of physical stock against the register were infrequent with the last full balance check recorded taking place in August 2023.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has a dedicated team of people who work together well. Pharmacy team members demonstrate enthusiasm for their roles. They know how to provide feedback and raise concerns at work. And they engage well in learning to support the safe delivery of pharmacy services. But sometimes team members experience a delay in the enrolment on accredited qualification training courses, which support them in developing in their roles.

Inspector's evidence

The RP was a regular locum who worked three days each week. They were supported by four trainee dispensers, one of who held the role of supervisor. The superintendent pharmacist (SI) and a pharmacist director for the company also worked regularly at the pharmacy with locums covering leave and days off. The pharmacy also employed two qualified dispensers, two pharmacy students and a delivery driver. There was flexibility in the team to cover for both planned and unplanned leave. And the pharmacy students worked extra hours during peak periods, such as before a bank holiday.

Trainee team members were enrolled on a GPhC accredited training course relevant to their role. But there had been some delays in enrolling some team members on an accredited course within three months of them commencing their role as required. Team members explained that recent appraisals had been used to identify training needs and support required to help them develop in their roles. They had engaged well in training for the change in PMR system in 2023. And a team member discussed the learning and support they had in preparing for their new role in supporting the delivery of the new NHS Pharmacy First service. The RP had completed training for this service and had engaged with GP colleagues to support them in delivering effective consultations. They had shared feedback from GP colleagues with the owner and SI and this had informed the variety of equipment the pharmacy had made available to support the safe delivery of the service.

The pharmacy team was not set specific targets to meet. Team members engaged with each other through regular conversations during the working day. This included a morning briefing to discuss workload and any matters for sharing. Team members rotated tasks at lunch time each day. For example, in the morning session they worked on the medicine counter, in the afternoon they dispensed prescriptions. A team member felt this helped with learning and meant that team members were not overly reliant on one individual to complete a specific task. The pharmacy had a whistleblowing policy and team members were confident in sharing feedback with each other and with the SI. They knew how they could escalate concerns if needed.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are secure and overall, they are clean, and tidy. They include suitable consultation areas allowing people to speak to a team member in private.

Inspector's evidence

The pharmacy was secure and maintained to an adequate standard. It was organised and generally clean with the exception of an area in a corridor leading through to a stock room where a patch of mould had developed following a water leak. The RP explained the leak was fixed and was aware of plans to permanently address any long-term issues with the roof during better weather. But the need to treat the internal damage had not been addressed to ensure it did not develop into a health and safety hazard. The RP acknowledged this and reported that he would feed this back to the owners. The pharmacy had periodic fire safety assessments from an external company. A very recent assessment had taken place following the pharmacy suffering a power surge. Maintenance issues caused by the power surge had been addressed in a timely manner following the event. Lighting was bright throughout the premises. And heating and ventilation arrangements were sufficient with air conditioning provided.

The public area of the pharmacy was fitted with wide spaced aisles. The dispensary was accessed down a short flight of stairs leading from behind the medicine counter. Pharmacy team members escorted people to and from the consultation room as the door to the room was behind the medicine counter. The room was clean and professional in appearance. People accessing some services attended a hatch at the back of the pharmacy. This hatch led to a room just off the dispensary, team members responded promptly to people knocking on the hatch for assistance. The dispensary was clean and orderly with dedicated areas for completing different tasks, such as a workbench solely used to complete tasks for the multi-compartment compliance pack service. Off the dispensary was a corridor with storage space for dispensary sundries and a good size stock room. Staff break facilities were also available onsite.

Principle 4 - Services Standards not all met

Summary findings

The pharmacy does not store all its medicines as it should. It obtains its medicines from reputable sources. And its team members complete a range of checks and audit processes which assist in providing its dispensing services safely. And the pharmacy's services are fully accessible to people.

Inspector's evidence

People accessed the pharmacy from street level. The pharmacy advertised its opening hours. And information about the services it provided. A screen near the medicines counter provided valuable information to people about appropriate use of antibiotics. The pharmacy protected Pharmacy (P) medicines from self-selection by displaying these behind transparent plastic screens in the public area. There was signage advising people to seek the assistance of team members when requesting a P medicine. The RP demonstrated additional safety flags that appeared on the pharmacy till when higher-risk P medicines, subject to misuse, were scanned. And the RP explained that team members would bring requests for P meds to their direct attention. But not all P medicines were flagged in this way. This meant there was a chance of a team member not identifying a P medicine and referring to the RP. The pharmacy was actively providing the new NHS Pharmacy First service. The team had supportive information available to support the safe delivery of this service, including current versions of the national patient group directions. And checklists to support team members in triaging people attending for the service.

The team used the PMR to help identify higher-risk medicines during the dispensing process. And pharmacists provided counselling when handing out these medicines. Team members were aware of medicines requiring supply in the manufacturers original packaging, including valproate. And they had knowledge of the checks required to support the valproate pregnancy prevention programme. There was a range of tools available to support counselling when supplying higher-risk medicines to people. But these types of verbal interventions were not recorded on the PMR to support continual care.

The pharmacy promoted a paperless workflow for most activity. This included referring to electronic prescription tokens on computer screens throughout the dispensing process rather than printing them in the majority of cases. And it prominently advertised to people how they could order repeat prescriptions without relying on paper repeat slips. Pharmacists transcribed information to the PMR system when dispensing hand-written prescriptions. Team members were responsible for applying a separate check of this information during the dispensing process. Pharmacists also transcribed information from prescriptions to the pharmacy's automated dispensing machine to support the safe supply of substance misuse medicines. The team kept robust records of the substance misuse medicines it dispensed. This allowed team members to identify gaps in treatment and report these through to the substance misuse team effectively.

Pharmacy team members used baskets throughout the dispensing process to help keep all items for each prescription together. They took ownership of their work by using individual logins on the PMR, a QR code on the medicine label provided information about who had been involved in the dispensing process. And team members physically signed backing sheets when dispensing medicines in multi-compartment compliance packs. The pharmacy retained prescriptions for the medicines it owed to

people. It used a digital application to support it in delivering medicines to people. This software helped the team to plan effective delivery routes and provided real time updates about the status of a delivery should the team receive a query. The pharmacy had an effective schedule to support it in managing work when supplying medicines in multi-compartment compliance packs. Team members used the PMR system to support it in supplying medicines in this way. A sample of compliance packs found clear descriptions and dispensing audit trails on the attached backing sheets. But patient information leaflets were not provided in the sample of compliance packs seen.

The pharmacy sourced medicines from licensed wholesalers and specials manufacturers. It generally stored medicines in an orderly manner with most stored within their original packaging. But some medicines were found in stock which were not kept in their original packaging. This was discussed with the team and the medicines were removed from stock. The pharmacy did not hold all medicines subject to safe custody arrangements correctly in legally compliant cabinets. It held medicines requiring cold storage in suitable fridges equipped with thermometers. The pharmacy kept temperature records for the fridges which showed they were operating within the required range of two and eight degrees Celsius. Team members explained they completed regular date checking tasks, but they did not keep a record of this activity. The PMR system flagged any expired medicines when team members scanned them. A random check of dispensary stock found one out-of-date medicine. Team members annotated bottles of liquid medicines with their date of opening. This prompted checks to ensure any medicine remaining in a bottle was safe to dispense. They transferred some stock of a higher-risk liquid medicine to larger bottles for use with the pharmacy’s automated dispensing machine. Team members recorded the batch number of the medicine and expiry date on the larger bottle at the time of transferring the medicine. They explained how they cleaned the bottles between use. But did not keep a record of this activity. The pharmacy had appropriate medicine waste receptacles and sharps bins available. It received medicine alerts through email and the team acted in a timely manner to check the alerts it received.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs to provide its services effectively. And pharmacy team members use the equipment in a way which protects people's confidentiality.

Inspector's evidence

Pharmacy team members had access to the internet and a range of resources held electronically. They used passwords and NHS smart cards when accessing people's medication records. The team stored bags of assembled medicines safely within the dispensary. This prevented people's personal information on bag labels and prescriptions from unauthorised view. Team members used specific pharmacy owned mobile phones for scanning bags of assembled medicines to shelves and when delivering medicines to people. The phone used by the delivery driver was returned to the pharmacy at the end of the delivery run. The pharmacy had cordless telephone handsets and the RP made a conscious effort to answer the telephone themselves when able to do so.

The pharmacy had a good range of equipment to support it in delivering its services. Equipment to support the delivery of consultation services, including the new NHS Pharmacy First Service was from recognised manufacturers and stored appropriately in the consultation room. This equipment included single-use tips in varied sizes for use with the otoscope. The pharmacy had a service contract for the automated dispensing machine and team members completed calibration checks of this machine daily. The pharmacy had a range of clean counting and measuring equipment for liquids, tablets, and capsules.

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.