General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Well, 22 Park Lane, Thrybergh, ROTHERHAM, South Yorkshire, S65 4BT

Pharmacy reference: 1039230

Type of pharmacy: Community

Date of inspection: 09/12/2019

Pharmacy context

This is a community pharmacy in a village on the outskirts of Rotherham in South Yorkshire. The pharmacy sells over-the-counter medicines and dispenses NHS prescriptions and private prescriptions. It offers advice on the management of minor illnesses and long-term conditions. It supplies medicines in multi-compartment compliance packs, designed to help people remember to take their medicines. And it provides medicines to people living in two local care homes. The pharmacy offers a medicine delivery service to people's homes.

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	1.2	Good practice	The pharmacy has robust review processes which help demonstrate how it manages the risks associated with its services. Pharmacy team members act openly and honestly by sharing information when mistakes happen. They contribute to regular safety reviews to share their learning. And they demonstrate how they act to reduce risks.
2. Staff	Good practice	2.2	Good practice	Pharmacy team members benefit from planned learning time and structured learning reviews. This encourages them to engage in continual learning associated with their roles. And means they keep their skills and knowledge up to date.
		2.4	Good practice	Pharmacy team members are enthusiastic about their job roles. They contribute to regular safety reviews. And they show how these reviews help to reduce risks across the pharmacy.
		2.5	Good practice	The pharmacy encourages its team members to share their ideas and concerns. And it considers this feedback and has uses it to inform the approach the team takes to managing 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 the risks associated with its services. It has robust review processes which help demonstrate how it manages these risks. Pharmacy team members act openly and honestly by sharing information when mistakes happen. They contribute to regular safety reviews to share their learning. And they demonstrate how they act to reduce risk. The pharmacy keeps people's private information secure. And it has appropriate arrangements for managing feedback and concerns. The pharmacy keeps the records required by law up-to-date. And it has appropriate systems in place to support its team members in recognising and reporting safeguarding concerns. So, they are able to act to help protect the safety and wellbeing of vulnerable people.

Inspector's evidence

The pharmacy had a set of up-to-date standard operating procedures (SOPs). The superintendent pharmacist's team reviewed these on a rolling two-year cycle. Pharmacy team members accessed SOPs electronically. And completed learning through watching videos and completing assessments to confirm their understanding of each SOP. The responsible pharmacist (RP) demonstrated training records which confirmed the pharmacy team was at 99% completion. The one SOP waiting to be completed by a trainee member of the team was associated with a task she had not yet been involved in. Pharmacy team members were observed working in accordance with dispensary SOPs. And they explained how they followed the company's 'Best in Class' guidance to support them in delivering services safely. They explained how this guidance supported them in recognising and managing risks associated with the supply of medicines. For example, by using clear bags to package multi-compartment compliance packs, they were able to check the name and address on the bag label against that on the packs prior to handing them out. A trainee dispenser discussed her job role and explained clearly what tasks could not take place if the RP took absence from the premises.

The dispensary appeared small. But pharmacy team members demonstrated how they used space effectively to manage their workload. There was separate space for labelling, assembling and accuracy checking medicines. And the RP most often completed clinical checks of prescriptions waiting to be sent to the off-site dispensing hub in the consultation room. She explained how this allowed her a distraction free environment for focussing on these checks. Pharmacy team members managed tasks associated with the care homes in a separate room on the first-floor level of the pharmacy.

The pharmacy had a near-miss error reporting procedure. The RP entered mistakes on a record in the dispensary in the first instance. And feedback about the mistake was provided to the member of the team involved at this point. Pharmacy team members explained they then took over responsibility for entering their mistake on an electronic system, 'Datix'. And they explained how this approach helped prompt reflective learning. A pharmacy team member provided examples of how the team discussed and acted upon their mistakes to help reduce risk. For example, hazard tape was used in the dispensary drawers to highlight the need for extra care when dispensing 'look-alike' and 'sound-alike' (LASA) medicines. The pharmacy reported dispensing incidents. And the RP explained her approach to managing and correcting dispensing incidents. This involved establishing the expectations of the person affected by the mistake. And identification of further learning. A recent incident had led to some shared learning relating to the difference in inhaler devices. And the pharmacist who had been covering at the

pharmacy on the date the incident occurred had contacted the pharmacy manager after learning of the incident. The manager explained this had provided an opportunity to feedback and promote wider learning.

The RP was the pharmacy manager. She led monthly patient safety reviews with the team. And these reviews focussed on identifying trends in mistakes and learning from them. Pharmacy team members discussed actions taken in response to recent reviews. For example, they had separated different formulations of risperidone in the dispensary drawers. And the pharmacy team could demonstrate how wider learning following company newsletters was used to encourage learning and review. For example, the placement of higher-risk medicines involved commonly in mistakes.

The pharmacy was good at planning and identifying risks associated with its services. And it did this by completing risk reviews and identifying training requirements ahead of introducing new services. For example, the pharmacy had completed a 'central fulfilment summary review' prior to sending prescriptions to its offsite hub pharmacy. The review included a validation exercise of labelling accuracy. And pharmacy team members explained how they kept their knowledge of the service up to date by engaging in regular discussions and learning. For example, pharmacy team members discussed the main benefits they had seen after changes were applied to the offsite dispensing model in October 2019.

The pharmacy had a complaints procedure in place. It advertised how people could provide feedback or raise a concern about the pharmacy in its practice leaflet. And this was available in the public area of the pharmacy. A team member explained how she would manage and escalate a concern to the manager. And pharmacy team members demonstrated how they had taken feedback from a care home onboard recently. The pharmacy also engaged people in feedback through an annual 'Community Pharmacy Patient Questionnaire'.

The pharmacy had up-to-date indemnity insurance arrangements in place. The RP notice displayed reflected the correct details of the RP on duty. The sample of the RP record examined was completed in accordance with legal requirements. Entries in the pharmacy's prescription only medicine (POM) register generally complied with legal requirements. One recent entry did not include a date of dispensing. The pharmacy did not dispense unlicensed medicines regularly. But a record for a recently supplied unlicensed medicines had been made in accordance with the requirements of the Medicine & Healthcare products Regulatory Agency (MHRA). The pharmacy maintained running balances of controlled drugs (CDs) within its CD register. And it generally completed full balance checks against physical stock weekly. These checks had extended to up to a month at one point over the summer of 2019. And this was contributed to the launch of the offsite dispensing service. A physical balance check of Medikinet XL 10mg capsules complied with the balance of the CD register. The pharmacy kept a patient returned CD register. And pharmacy team members wrote returns into the register on the date of receipt.

The pharmacy displayed a privacy notice. And pharmacy team members had completed learning associated with the procedures in place for managing confidential information. These procedures had been updated following the introduction of the General Data Protection Regulation (GDPR). The pharmacy had submitted its annual NHS Data Security and Protection (DSP) Toolkit as required. It stored all personal identifiable information in staff only areas of the pharmacy. And people visiting the pharmacy were escorted by staff if they required access through a staff only area. For example, access beyond the medicine counter was required to reach the consultation room. Pharmacy team members transferred confidential waste to 'Shred-it' sacks. These were sealed and collected by the waste management contractor for secure disposal at periodic intervals.

The pharmacy had procedures and information relating to safeguarding vulnerable adults and children. And contact information for local safeguarding agencies was prominently displayed. It displayed a chaperone notice to people. All pharmacy team members had completed safeguarding e-learning. And the RP had completed level two safeguarding learning through the Centre for Pharmacy Postgraduate Education (CPPE) . A pharmacy team member explained how she would recognise and report a safeguarding concern. The pharmacy team had shared minor concerns relating to medicine compliance issues with people's GPs.

Principle 2 - Staffing ✔ Good practice

Summary findings

The pharmacy employs enough qualified and skilled people to provide its services. And it monitors its staffing levels effectively. Pharmacy team members benefit from planned learning time and structured learning reviews. This encourages them to engage in continual learning associated with their roles. And they are supported in developing their skills to help manage the safe delivery of the pharmacy's services. Pharmacy team members are enthusiastic about their job roles. They contribute to regular safety reviews. And they show how these reviews help to reduce risk across the pharmacy. The pharmacy encourages its team members to share their ideas and concerns. And it considers this feedback and uses it to inform the approach the team takes to managing its services.

Inspector's evidence

On duty during the inspection was the RP, a qualified dispenser and a trainee dispenser. The pharmacy also employed a delivery driver and two other qualified dispensers. Relief and locum pharmacists covered the manager's days off and there was some flexibility within the team to cover some annual leave and unplanned leave. The RP demonstrated a 'staffing and capability' review she had completed prior to care home dispensing beginning in September 2019. The review looked at staffing capacity and the time taken to complete tasks associated with the pharmacy's services. The pharmacy had been due to lose nine hours of support staff cover following a move of some of its dispensing to the company's hub pharmacy. The RP confirmed that her regional development manager had listened to her staffing concerns and had taken onboard the results of the review. And the nine hours had been protected for a further few months.

The trainee dispenser confirmed that she received time and support to assist her in her learning. All team members received regular time to complete ongoing learning associated with their roles. This learning ranged from completing quizzes following learning associated with SOPs to learning about current health campaigns. Pharmacy team members were also committed to shared learning. A dispenser explained how pharmacy team members had sought support with tasks associated with personalising medication administration records (MARs) to the needs of the care home. And they had recently discussed the requirements of the isotretinoin pregnancy prevention programme (PPP), should the pharmacy receive a prescription for this medicine. Pharmacy team members had received training and support prior to undertaking tasks associated with the supply of medicines to a care home. All pharmacy team members benefitted from formal appraisals to support their learning and development. The trainee dispenser had engaged in regular discussions with the RP and a formal review following her induction period coming to an end.

Pharmacy team members were engaging with people. And they knew most people visiting the pharmacy by name. They were observed checking names and addresses when handing out assembled medicines. And referring requests for advice to the RP. The RP counselled people on the use of their medicines and was observed making safety checks prior to handing out assembled medicines. For example, checking a person's allergy status when dispensing a prescription for penicillin. Pharmacy team members engaged in regular discussions relating to targets the pharmacy had for the services it provided. And they assisted pharmacists by highlighting bags of assembled medicines with details of services people were eligible for. The RP had a positive attitude about the use of targets. And explained

clearly how she strived to provide quality services where there was the potential for a positive outcome for people.

Pharmacy team members worked well together. They engaged in team discussions and exercises to help share their learning and promote safe practice. The RP led a patient safety review each month. And this identified learning from mistakes. And set clear actions for improvement and learning. Information received from the superintendent pharmacist's office was included within this review. For example, ' Safe and Well' updates which focussed on supporting teams in identifying and managing risks when providing the pharmacy's services. And pharmacy team members could demonstrate how this learning was applied to help reduce risk. For example, they had refreshed their knowledge on how to make and keep records associated with the supply of unlicensed medicines recently. This was following the pharmacy receiving a prescription for an unlicensed medicine, which had been its first for some time. All team members spoken to confirmed they felt well supported by the pharmacy manager. The pharmacy had completed a reactive risk review in autumn 2018 following concerns that not all near-miss errors were being managed effectively. The review documented trends in near-miss learning. And improvements required to improving compliance with formal recording of these types of mistakes. And pharmacy team members had engaged in further learning to support them in their roles following the review. A dispenser explained how the review had helped the pharmacy team identify and manage risks.

The pharmacy had a whistle blowing policy. And it engaged its team members in feedback through satisfaction questionnaires. Pharmacy team members on duty confirmed they were confident in feeding back any concerns they had about the pharmacy or pharmacy team to the manager. And they were aware of how they could escalate a concern if needed. They explained that they would often share ideas or feedback openly with each other. And they provided examples of how the pharmacy used their feedback to help inform the safe provision of its services. For example, pharmacy team members had recently taken responsibility for monitoring their own stock sections within the dispensary. And they explained this was working well to ensure the pharmacy did not run short of the medicines it most commonly dispensed.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean, secure and suitably maintained. 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 professional in appearance and it was secure. The public area was small and open plan. It was accessible to people using wheelchairs and pushchairs. And it had seating provided for people waiting for prescriptions or services. The pharmacy had an unusual layout as its private consultation room was down a short corridor behind the medicine counter. The room was small. But it was professional in appearance. And the RP confirmed a person using a wheelchair was able to access the room. The room allowed staff to maintain confidentiality when providing counselling about medicines or when holding private discussions with people.

The dispensary was an adequate size for the level of activity taking place. Pharmacy team members explained how they would assemble multi-compartment compliance packs in the dispensary during quieter periods to help limit the risk of distraction during the dispensing process. A stairway leading from the back of the dispensary provided access to the first-floor level of the pharmacy. This level consisted of staff facilities, storage space and a good size room which was fitted out as a second dispensary. Pharmacy team members used this room to complete tasks associated with supplying medicines to the care homes.

The pharmacy had suitable heating arrangements. But the sensor on the pharmacy's door was extremely sensitive. And as such the automatic opening feature on the door was activated by gusts of wind throughout the inspection. Pharmacy team members confirmed this was a common occurrence. Lighting was bright throughout the premises. Pharmacy team members completed all cleaning tasks. And the pharmacy was clean. Work benches were free of clutter and floors were clear of trip or fall hazards. Pharmacy team members reported maintenance concerns to the pharmacy's head office. And they confirmed responses to requests were timely. A maintenance contractor was fixing an issue with the staff room sink during the inspection.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's services are accessible to people. It has some good management processes to help identify and manage the risks associated with providing its services. The pharmacy engages in national audits to help ensure people receive appropriate care to manage their health. And people using the pharmacy receive relevant information about the medicines they are taking. The pharmacy obtains its medicines from reputable sources. And it stores and manages them appropriately to help make sure they are safe to use. It has appropriate systems in place to provide assurance that its medicines are fit for purpose.

Inspector's evidence

The pharmacy was accessed through an automatic door at street level. It advertised details of its services. And it promoted national health campaigns and information about its services. Pharmacy team members understood the requirement to signpost people to another pharmacy or healthcare provider if they were unable to provide a service. And they explained how they had to signpost people to the neighbouring surgery's main practice if they required a GP service when the village satellite surgery was closed.

Pharmacy team members were observed promoting the flu vaccination service. And the pharmacy had up-to-date and legally valid patient group directions (PGDs) in place for this service. The RP provided evidence of the local emergency hormonal contraception (EHC) protocol. This protocol allowed pharmacists to supply over the counter EHC to people in the inclusion criteria free of charge. The RP explained that referrals to the GP from the Medicines Use Review (MUR) service were relatively low. But the pharmacy had identified and referred a number of people through a recent diabetic foot and eye audit. The audit had been used to identify diabetics who had not received an eye or foot check within the last 12 months. And the RP reflected on the number of successful referrals to add in suitable gastric protection for people in the high-risk group taking non-steroidal anti-inflammatory drugs (NSAIDs).

The RP explained how she counselled people on the use of high-risk medicines. And this included monitoring people on warfarin to ensure they were having regular blood tests. But the pharmacy did not always use the stickers on assembled bags of medicines. These stickers identified the need for this counselling. This meant there was a potential for other pharmacists to miss an opportunity to talk to people about their medicines. The pharmacy had the tools required to comply with the valproate pregnancy prevention programme (PPP). And they had identified people in the high-risk group. Details of a person's PPP status was recorded on their patient medication record. And pharmacy team members understood the requirement to supply a high-risk warning card to people in the high-risk group when dispensing valproate preparations.

The pharmacy used colour coded 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. And it used the prescription throughout the dispensing process when the medicine was later supplied. The pharmacy kept an audit trail for its

delivery service. And people were asked to sign for receipt of their medicines through the service. The pharmacy team members demonstrated the processes they followed when preparing prescriptions for offsite dispensing. These involved pre and post accuracy checks of information and assembled medicines. Pharmacy team members used an electronic scanning device which tracked the prescription through the entire dispensing process. If part of the prescription was sent to the hub and part was dispensed locally, it clearly provided details of where each bag of assembled medicines was stored prior to hand out. This mitigated the risk of people only being supplied with part of their prescription.

The pharmacy organised its workload associated with the multi-compartment compliance pack service across a four-week rolling rota. A dispenser explained how the pharmacy was able to order prescriptions for these people from surgeries. It ordered 'when required' (PRN) medicines for people upon request. Individual profile sheets were in place for each person on the service along with 'medication event diaries'. Profile sheets did not regularly include the formulation of the medicine. A discussion took place about the benefits of adding this information. This would support the three-way check between the medicine, prescription and profile that the team members completed during the dispensing process. Pharmacy team members recorded details of medicine changes and the checks they made to confirm these changes clearly within the medication event diaries. A sample of assembled packs contained full dispensing audit trails and start dates of individual packs. The pharmacy provided descriptions of the medicines inside the pack to help people identify them. It supplied patient information leaflets at the beginning of each four-week cycle of packs.

The pharmacy supplied medicines to one small care home in original packs. And it supplied MAR sheets with these packs. It supplied another care home with the medicines through a racked multi-compartment compliance pack system. A member of the staff from the pharmacy team within the local NHS Clinical Commissioning Group (CCG) ordered prescriptions for people in the home. A copy of the previous MAR sheet was sent to the pharmacy to inform the pharmacy what medicine had been ordered. And what medicine was to continue on the MAR. Pharmacy team members checked this information and recorded any queries they made in a medication event diary. A sample of assembled packs contained full dispensing audit trails. And patient information leaflets were provided at the beginning of each four-week cycle. And when supplying interim medicines. The pharmacy supplied prescriptions for interim medicines it received by 3pm the same day to the home. And it provided MAR sheets with these medicines.

The pharmacy sourced medicines from licensed wholesalers and specials manufacturers. Its clinical computer system had been updated within the last six months. The RP explained how the system had functionality to comply with the requirements of the Falsified Medicine Directive (FMD). Pharmacy team members had completed some e-learning associated with FMD. And could demonstrate the checks they made to ensure new tamper proof packaging was intact before supplying a medicine. But the pharmacy had not yet begun scanning the unique 2D barcode on some medicines to comply with FMD requirements. And pharmacy team members were not yet aware when this process would begin locally.

The pharmacy stored Pharmacy (P) 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 in the dispensary in an organised manner and within their original packaging. The pharmacy team followed an electronic date checking rota to help manage stock and it recorded details of the date checks it completed regularly. A new storage area for medicines had been created in the upstairs dispensary. And the RP confirmed this would be included in the 'bulky items' section of the date checking rota moving forward. The pharmacy identified short-dated medicines well. And pharmacy team members annotated details of opening dates on bottles of liquid medicines. No out-of-date

medicines were found during checks of dispensary stock. Medical waste bins, sharps bins and CD denaturing kits were available to support the team in managing pharmaceutical waste. The pharmacy received medicine alerts and drug recalls electronically. It had a system for checking and responding to these types of alerts. All alerts were actioned to date.

The pharmacy held CDs in a secure cabinet. Medicine storage inside the cabinet was orderly. It was an appropriate size for the level of stock kept. Patient returned CDs and out-of-date CDs were generally segregated from stock and labelled. An open bottle of methadone oral solution required segregating and labelling as it had been open for longer than the 28-day period indicated on the bottle. The bottle had not been used beyond its 28-day shortened expiry date. The pharmacy stored assembled CDs in clear bags and prescriptions attached to the bags were clearly highlighted with details of the prescription's validity period. This enabled the pharmacist to check the validity of the prescription before supplying a CD. And it prompted additional checks throughout the dispensing process. The pharmacy stored its cold chain medicines within a medical fridge. It used clear bags to store assembled medicines. This prompted additional checks prior to hand out. The pharmacy team monitored fridge temperatures. And records examined confirmed cold chain medicines were stored within the required temperature range of two and eight degrees Celsius.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs for providing its services. 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 also had access to the company intranet and the internet which provided them with further resources such as Medicines Complete. The pharmacy's computers were password protected. And information on computer monitors was protected from unauthorised view due to the layout of the pharmacy. The computer monitor in the consultation room remained locked when not in use. Pharmacy team members used NHS smart cards to access people's medication records.

The pharmacy stored bags of assembled medicine on shelves between the dispensary and consultation room. Details on bag labels could not be seen from the public area of the pharmacy. But people did have to walk past the shelves when accessing the consultation room. The RP demonstrated how pharmacy team members managed the risk of breaching people's confidentiality by escorting people at all times. She explained that frosted doors for the unit had been requested some time ago. But the request had been put on hold. The pharmacy had a cordless telephone handset. This helped to protect people's confidentiality as pharmacy team members were able to move out of earshot of the public area when discussing confidential information over the telephone.

Clean, crown stamped measuring cylinders were in place for measuring liquid medicines. And these included separate measures for use with methadone. The pharmacy had clean counting equipment for tablets and capsules. Pharmacy team members had access to appropriate equipment for assembling medicines in multi-compartment compliance packs. The pharmacy's electrical equipment had been safety checked in September 2019. A blood pressure machine had also been checked at this time to ensure it was in working order. Equipment to support the flu vaccination service was readily available. But two adrenaline autopens in the consultation room had recently expired. The RP had access to adrenaline ampoules which were stored in the room and further supplies of adrenaline autopens were stored on site. The RP removed the out-of-date autopens. And a discussion took place about the importance of including the consultation room when carrying out date checking tasks. The RP confirmed that additional tasks were being introduced to support date checking. This would also include the new stock area used to store some medicines the pharmacy supplied to care homes.

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.