General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Well, Wickersley Health Centre, Poplar Glade, Wickersley, ROTHERHAM, South Yorkshire, S66 2JQ

Pharmacy reference: 1039231

Type of pharmacy: Community

Date of inspection: 20/03/2023

Pharmacy context

This pharmacy is situated alongside a health centre in the South Yorkshire village of Wickersley, on the outskirts of Rotherham. Its main services include dispensing NHS prescriptions and selling over-the-counter medicines. It is also a COVID-19 vaccination centre. 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 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	N/A	N/A	N/A
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 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 effectively. It advertises how people can provide feedback about the pharmacy. And it keeps people's confidential information secure. The pharmacy generally keeps the records it is required to by law in good order. And it makes information available to support its team members in recognising and acting on concerns to help keep vulnerable people safe. Pharmacy team members behave openly and honestly by sharing information when they make mistakes during the dispensing process. And they act to reduce risk following these mistakes.

Inspector's evidence

The pharmacy had standard operating procedures (SOPs) to support its safe and effective running. These covered responsible pharmacist (RP) requirements, controlled drug (CD) management, dispensary processes and pharmacy services. The pharmacy held the SOPs electronically and its superintendent pharmacist's team reviewed them on a rolling two-year rota. A sample of training records confirmed team members had completed learning associated with the SOPs. And observations confirmed team members worked in accordance with the SOPs when completing tasks associated with dispensing and delivering medicines. The pharmacy had implemented specific SOPs in 2021 to support the safe management of the COVID-19 vaccination service. This service was currently on pause, the team expected the pharmacy to recommence the service as part of the Spring 2023 NHS booster programme.

Pharmacy team members recorded mistakes that they made and identified during the dispensing process, known as near misses. The recording process included initially recording details of the mistake on a paper-based near miss log prior to transferring details of the mistake to an electronic reporting tool. This electronic reporting tool was also used to record mistakes that were made and identified following the supply of a medicine to a person, known as dispensing incidents. The reporting tool was used to support the identification of trends in mistakes. And this information was used to inform regular patient safety reviews to share learning and drive actions designed to reduce risk. The team demonstrated the recent actions that it had taken to reduce risk. For example, they had segregated medicines in similar packaging and with similar names from each other within the dispensary drawers. Team members showed a focus on identifying risk during their day-to-day tasks. For example, they shared information related to medicines in similar packaging when unpacking the medicine order. This alerted team members to the need to apply caution when storing and selecting these medicines.

The pharmacy had a complaints procedure, and this was advertised. Pharmacy team members knew how to manage feedback and they understood how to escalate a concern when required. A team member explained that concerns would be recorded on the electronic reporting tool to support an investigation into the event that had occurred. The pharmacy had procedures to support its team members in managing a concern about a vulnerable person. Pharmacy team members had completed some learning associated with protecting vulnerable people. And they understood how to recognise and raise these types of concerns. Information to support the team in contacting safeguarding agencies was displayed in the dispensary.

The pharmacy displayed a privacy notice informing people of how it managed their information. It stored personal identifiable information in staff-only areas of the premises. It held confidential waste securely and this was collected periodically by a secure shredding service. The pharmacy had up-to-date indemnity insurance. The RP notice displayed contained the correct details of the RP on duty. The pharmacy had recently switched from a paper-based to an electronic RP record. Some RPs had not recorded a sign-out time in the new electronic register. A sample of records associated with private prescriptions and the supply of unlicensed medicines were seen to be completed in accordance with requirements. The pharmacy held its CD register electronically. Records conformed to legal requirements. The pharmacy checked physical stock levels against the balances recorded in the CD register most weeks. It held a record of patient returned CDs and team members entered these into the record at the time of receipt.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy employs a dedicated team of people with the knowledge and skills to provide its services safely. Pharmacy team members engage in continual learning associated with their roles. They work together well to support each other and to share information and learning. And they understand how to raise a professional concern if needed.

Inspector's evidence

The RP on duty was a relief pharmacist who worked regular Mondays at the pharmacy. They were working alongside four qualified dispensers and a delivery driver. A full-time pharmacist manager, a pharmacy technician working as an accuracy checking technician (ACT) and two other qualified dispensers worked at the pharmacy. One team member was on long-term leave, and another was on annual leave. The remaining team members were not aware of any regular backfill to cover these hours and overtime hours for the current week had yet to be authorised. An ACT from another pharmacy had worked at the pharmacy on several occasions to support the team manage workload associated with the multi-compartment compliance pack service. They had generally worked at the pharmacy for a few hours at a time. Workload was relatively up to date. The pharmacy used the company's offsite dispensing hub to help it manage its workload, some bags of assembled medicines returned from the hub from the previous working day were still being processed. Team members explained this backlog was due to similar levels of absence within the team the previous week. They were observed working together well and managed the demands of acute workload effectively by balancing these demands alongside other tasks.

Pharmacy team members completed some ongoing learning relevant to their role. This included learning associated with the pharmacy's SOPs and services. Recently issued training certificates indicated that team members had engaged in some e-learning about the early diagnosis of cancer. The pharmacy monitored the completion of learning and team members explained they could complete the learning in work or at home in their own time. The RP discussed the pharmacy's targets to support service delivery. These included targets associated with the NHS New Medicine Service (NMS) and the NHS Hypertension Case-Findings Service. They explained how the services were managed, with team members supporting in identifying people who may benefit from these services during the dispensing process. And they felt able to apply their professional judgment when working at the pharmacy. Pharmacy team members engaged in regular conversations and team briefings to share information at work. This included managing day-to-day workload and sharing information and learning on a regular basis. Patient safety reviews were recorded and left for team members to read. The pharmacy had a whistle blowing policy. Its team members understood how to raise concerns at work, and how to escalate these if needed.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is secure and maintained to an appropriate standard suitable for delivering healthcare services. People visiting the pharmacy can speak to a team member in confidence in a quiet and professional space.

Inspector's evidence

The pharmacy was secure and appropriately maintained. There was one outstanding maintenance concern on the day of inspection relating to a broken heater in the staff kitchen. The team on duty was not aware if this had been reported. The pharmacy was clean and generally organised. It had plinth heaters to heat the premises in winter months, and fans were available to circulate air. Lighting was sufficient throughout the premises. Pharmacy team members had access to sinks equipped with antibacterial hand wash and paper towels. And kitchen and toilet facilities for team members were available within the premises.

The public area was a good size. An area near the consultation room was open plan, and the area closer to the medicine counter was separated into two wide aisles. The consultation room was advertised clearly. It was clean and tidy. And it was kept secure from unauthorised access. It offered a professional and confidential space for people wanting to speak to a team member in private. The room was well set out with equipment to support services readily available and stored safely. The team used space in the main dispensary effectively to manage acute and planned workload. Pharmacy team members used a long workbench at the back of the dispensary to complete labelling and assembly tasks. There was sufficient holding space for baskets of medicines waiting to be checked and those waiting to be completed on a heightened shelf at the back of the workbench. The front workbench provided protected space for accuracy checking and administration tasks. To the side of the main dispensary was a separate area dedicated to support tasks associated with the multi-compartment compliance pack service. Space in this area was managed well.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's services are fully accessible to people. It has processes which help team members deliver its services safely. And it ensures people using the pharmacy receive relevant information about the medicines they are taking. The pharmacy obtains its medicines from reputable sources. And overall, it stores and manages its medicines safely.

Inspector's evidence

People accessed the pharmacy through a simple push/pull door at either side of the public area. The pharmacy displayed its opening times and details of the services it provided. It had a range of health information leaflets and posters within its designated waiting area. It had chairs available in this area for people waiting for their medicine or a service. Pharmacy team members knew how to signpost people to other local pharmacies and healthcare providers should they be unable to supply a medicine or provide a service.

The pharmacy protected Pharmacy (P) medicines from self-selection as it displayed them behind the medicine counter and in plastic units to the side of the medicine counter. And the RP was able to supervise the activity taking place in the public area from the dispensary. The pharmacy held assembled cold-chain medicines and CDs in clear bags. This informed additional safety checks when handing out these medicines. The RP described the verbal counselling that was provided to people when handing out these medicines. And demonstrated the range of tools the team used to support it in supplying higher-risk medicines, such as providing monitoring booklets to people. The pharmacy also highlighted bags of assembled medicines containing antibiotics. This prompted checks to ensure people collected this often-urgent treatment in a timely manner. Pharmacy team members had understood the requirements of the valproate Pregnancy Prevention Programme (PPP). They had recently engaged in an audit focussed on the safe supply of valproate to people within the at-risk group. The RP demonstrated how information relating to counselling when supplying valproate to a person in the at-risk group was recorded on the patient medication record (PMR).

The pharmacy used coloured baskets throughout the dispensing process. This effectively kept medicines with the correct prescription form and helped inform workload priority. Pharmacy team members routinely signed the ‘dispensed by’ and ‘checked by’ boxes on medicine labels to form a dispensing audit trail. The pharmacy had a system for managing the medicines it could not supply immediately, known as owings. The number of medicines owed to people was higher than normal levels. This was due to issues within the medicine supply chain and was outside of the pharmacy’s control. The team discussed how they communicated information about out-of-stock medicines to surgery teams. The pharmacy had an electronic audit trail of the medicines it delivered to people’s homes. This supported the team in answering any queries relating to the service.

The pharmacy used individual patient record sheets when supplying medicines in multi-compartment compliance packs. The records contained some supportive information about changes applied to people’s medicine regimens. But some information on a sample of record sheets was crossed out, and correction fluid was used on occasion to write over previous information. This made it more difficult to

read some of the record sheets and to track the change made. A sample of assembled compliance packs contained full dispensing audit trails and descriptions of the medicines inside them. The pharmacy routinely supplied patient information leaflets alongside compliance packs at the beginning of each four-week cycle.

A pharmacist accuracy checked the data the team sent to the company's offsite dispensing hub pharmacy. They also completed clinical checks of the prescriptions prior to securely transferring the data to the hub. The hub then dispensed the prescription and sent the medicine back to the pharmacy to be collected by or delivered to people. The turnaround time for the service was two working days. A pharmacy team member demonstrated how the team managed prescriptions when part was dispensed at the hub and part was dispensed in the pharmacy. They used barcode technology to track prescriptions through the entire dispensing process to support them in managing queries and to ensure all medicines on a prescription were handed out.

The pharmacy sourced medicines from licensed wholesalers. It generally stored medicines in an orderly manner, within their original packaging, in drawers throughout the dispensary. But some medicines were stored with others due to stock moving around when the drawers were opened and closed and the limited number of dividers. The pharmacy stored medicines requiring safe custody in secure cabinets. Medicines inside were stored in an orderly manner with separate areas for holding assembled medicines, out-of-date medicines, and patient-returned medicines. Some prescriptions associated with assembled medicines held inside a cabinet had expired, as these were only valid for 28-days. The RP provided assurances of the checks made by a pharmacist prior to handout of these medicines which would identify the expiry date of the prescription. The pharmacy had three fridges used to store medicines. Medicines inside were held in an orderly manner. Fridge temperature records confirmed they were operating within the correct temperature range of two and eight degrees Celsius.

The team kept an electronic record of its date checking tasks, the record contained some recent gaps which highlighted parts of the dispensary that had not been date checked for several months. The team had identified this risk and were applying additional care when dispensing medicines to ensure expiry dates were checked at several stages of the dispensing process. A random check of dispensary stock found no out-of-date medicines, but most short-dated medicines were not highlighted. The team generally annotated liquid medicines with details of their shortened shelf-life once opened. But a check of liquid medicine stock found an unannotated open bottle of a medicine known to have a shortened shelf life once opened. This was removed from stock and brought to the direct attention of the RP. The pharmacy had appropriate medical waste bins, sharps bins and CD denaturing kits available. It received and actioned medicine alerts electronically through a task tracker system on its intranet. But when completing checks associated with a very recent alert involving the withdrawal of pholcodine-containing medicines from the UK market the team had missed the stock of pholcodine within the dispensary. This was removed during the inspection and the RP acknowledged this as shared learning point.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the necessary equipment for providing its services. It maintains its equipment to ensure it remains fit for purpose and safe to use. And its team members use the equipment in a way which protects people's privacy.

Inspector's evidence

Pharmacy team members had access to current reference sources and to the internet to support them in obtaining information and providing advice to people. Pharmacy team members used NHS smart cards and passwords to access people's medication records. The layout of the premises protected information on the pharmacy's computer monitors from unauthorised view. The pharmacy stored bags of assembled medicines on designated shelving to the side of the dispensary. This arrangement effectively protected people's personal information.

The pharmacy had a range of clean and suitable equipment to support its team members in counting and measuring medicines. For example, they used crown stamped glass measures to accurately measure liquid medicines. And they used separate equipment when counting and measuring higher-risk medicines to mitigate the risk of cross contamination. Equipment used to support the delivery of pharmacy services was from reputable manufacturers. For example, the pharmacy's blood pressure monitors were on the list of monitors validated for use by the British and Irish Hypertension Society. There was a procedure to support appropriate cleaning of this equipment between use. The pharmacy maintained its equipment to help ensure it remained safe to use and fit for purpose. For example, electrical equipment was subject to regular portable appliance testing.

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.