General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Well, Rainbow Centre, MARKET DEEPING, Lincolnshire, PE6 8EA

Pharmacy reference: 1072881

Type of pharmacy: Community

Date of inspection: 22/10/2019

Pharmacy context

This is a community pharmacy in a small rural market town in South Lincolnshire. 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-compartmental compliance packs, designed to help people remember to take their medicines. And it delivers medicines 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	1.4	Good practice	The pharmacy encourages feedback from people using its services. And it proactively uses learning and feedback to help inform the management of new services. And to review and act upon identified risks to its dispensing services.
2. Staff	Standards met	2.4	Good practice	Pharmacy team members understand the importance of sharing learning. And they demonstrate how they use shared learning opportunities to help manage and monitor the safety of the pharmacy's services.
		2.5	Good practice	The pharmacy encourages its team members to share their ideas and concerns. And it considers this feedback and has used 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	4.1	Good practice	The pharmacy team engages well with people through positively promoting services that support people's health and wellbeing. And the pharmacy considers the specific needs of the local community by offering the flu vaccination service to staff at a local school.
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 encourages feedback from people using its services. And it proactively uses learning and feedback to help inform the management of new services. And to review and act upon identified risks to its dispensing services. The pharmacy team members are clear about their roles and responsibilities. And they have the knowledge required to recognise and report safeguarding concerns. This helps to ensure the safety and wellbeing of vulnerable people is managed effectively. Pharmacy team members openly discuss the mistakes they make during the dispensing process. And they engage fully in regular reviews to help identify and reduce risk in the pharmacy. The pharmacy manages people information securely. And it generally keeps the records required by law. But some minor gaps in the responsible pharmacist record may make it difficult for the pharmacy to respond to a query should one arise.

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 was at 98% completion. Pharmacy team members were in the process of completing some learning recently received which related to the multi-compartmental compliance pack service. Pharmacy team members discussed their roles and responsibilities. They had written job descriptions. And explained how they would refer back to SOPs if they needed to clarify information.

The dispensary was a sufficient size. Most work benches were full, but workflow was efficient. Pharmacy team members completed labelling and assembly tasks in different areas of the dispensary. And there was clear space to complete the final accuracy check of medicines. Pharmacy team members utilised storage under work benches to store baskets of assembled medicines waiting to be accuracy checked. This process reduced workload pressure on the RP.

The pharmacy had a near-miss error reporting procedure. It reported mistakes through its 'Datix' system. A dispenser explained how feedback would be given to the person involved in a near-miss error at the time the pharmacist found the mistake. And pharmacy team members discussed their mistakes openly to encourage shared learning. Near-miss error reporting patterns identified a rise in the number of near misses. And the RP confirmed this was due to a change in practice in the pharmacy as the team had recognised some occasions where a near-miss error had not been recorded. Pharmacy team members explained how the change encouraged reporting and learning opportunities.

The pharmacist led regular discussions when a mistake occurred. And followed this up by using the systems trend analysis function to inform a formal patient safety review at the end of the month. The RP explained the overarching review for September 2019 was outstanding due to the launch of the flu vaccination service. But pharmacy team members could demonstrate recent actions taken to reduce risk following the informal discussions which took place continuously. For example, they had placed high risk stickers on shelf edges following a near-miss error thought to be caused by medicines in similar packaging. And pharmacy team members explained how they shared details of 'look-alike and sound

alike' medicines with each other as they unpacked medicine orders.

Pharmacy team members were committed to learning when things went wrong. All pharmacy team members spoken to had good insight into how the pharmacy used feedback relating to dispensing incidents. And several examples of how thoroughly the pharmacy managed these types of concerns were discussed and demonstrated. For example, the pharmacy had reviewed its workflow and had made significant alterations following an incident which had involved a distraction at the accuracy checking stage. The RP had led a route cause analysis for a recent incident. And had shared learning from the incident with the prescriber as this had contributed to the error.

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. Several pharmacy team members explained how they would manage feedback and escalate concerns to the RP. A pharmacy team member explained how she had responded to some feedback about the handheld scanners the pharmacy team used. She explained it was easy to mistake the scanner for a mobile phone and was keen to share with people how the scanner helped informed safety processes. The pharmacy also engaged people in feedback through an annual 'Community Pharmacy Patient Questionnaire'. The pharmacy was pro-active to receiving feedback. And the RP explained how she had considered feedback about prescription dispensing timescales associated with the offsite dispensing model after spending time at another pharmacy. This had helped inform an information leaflet detailing ordering and collection timescales. And a copy of the leaflet was provided to people ahead of the offsite dispensing service being launched to help people ordering their prescriptions. A copy of the leaflet was available for people to take.

The pharmacy had up-to-date indemnity insurance arrangements in place. The RP notice was updated shortly after the inspection process began to reflect the correct details of the RP on duty. The sample of the RP record examined found missed entries for 22 July 2019, 23 July 2019 and 27 July 2019. The RP confirmed she had been on leave during this period and would share these findings with the relevant pharmacists. Samples of specials records, emergency supply records and private prescription records complied with legal and regulatory requirements. The pharmacy maintained running balances of CDs within its CD register. And it completed full balance checks against physical stock weekly. A physical balance check of Zomorph 10mg capsules complied with the balance of the CD register. There was some minor crossing out in the register. For example, when a calculation error occurred. And this practice was discouraged. The pharmacy did not always record the address of the wholesaler when entering a CD into the register. It maintained 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 a chaperone notice. It had procedures relating to information governance and compliance with the General Data Protection Regulation (GDPR). And pharmacy team members had engaged in additional learning following the introduction of GDPR requirements. 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 it had a secure 'Shred-it' bin and white sacks available for collecting confidential waste. These sacks were sealed by pharmacy team members and collected by the waste management contractor for secure disposal at periodic intervals. A collection took place at the time of inspection.

The pharmacy had procedures and information relating to safeguarding vulnerable adults and children. A pharmacy team member explained learning associated with safeguarding was provided within the pharmacy's SOPs. And the team had discussed safeguarding requirements. The RP had completed level two safeguarding training. A member of the team discussed how she would recognise and report a concern. And provided several examples of how concerns had been shared with surgery teams. And the

RP provided an example of how a concern referred to the surgery had been formally recorded on the clinical computer system. The pharmacy had access to contact information for local safeguarding agencies, in the event it needed to escalate a concern.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy employs enough qualified and skilled people to provide its services. Pharmacy team members demonstrate a positive attitude to continual learning. They are enthusiastic about their job roles and understand the importance of sharing learning. And they demonstrate how they use shared learning opportunities to help manage and monitor the safety of the pharmacy's services. The pharmacy encourages its team members to share their ideas and concerns. And it considers this feedback and has used it to inform the approach the team takes to managing its services.

Inspector's evidence

On duty during the inspection was the RP and four qualified dispensers. The pharmacy also employed a delivery driver and two other qualified dispensers. The pharmacy had lost 22 hours of dispenser support following the implementation of the company's offsite dispensing model. The RP, who was the pharmacy manager, confirmed this had led to an adjustment of the way the pharmacy team managed the workload. Prior to the introduction of offsite dispensing the pharmacy had also seen an increase in item numbers which had required new ways of working. The RP confirmed she felt supported by her regional manager. And could raise concerns about staffing if required. She explained there was an increased focus on building up the area relief team to support pharmacies. And the pharmacy had recently received some support from the relief team when a need was identified. All support staff worked part time which provided some flexibility. For example, the Saturday dispenser was providing cover for annual leave on the day of inspection.

One of the dispensers had very recently qualified. And she confirmed that she had been fully supported through her learning and development. The pharmacy kept electronic training records for its team members. Pharmacy team members had a good focus on continual learning such as refreshing their knowledge of SOPs and completing e-learning modules. They explained training time could feel rushed at times due to the pharmacy being busy. And discussed how they managed their approach to training associated with new services to maximise the time available. For example, they read through procedures and then strengthened their learning by completing tasks associated with them. They then revisited procedures as a team to review any improvements required.

Pharmacy team members were observed liaising well with people visiting the pharmacy. They referred people to the RP when additional advice or support was required. Pharmacy team members were aware of targets the pharmacy had for its services. And the RP confirmed the pharmacy consistently delivered against these targets. She had a positive attitude when discussing pharmacy services and provided several examples of how she applied her professional judgement when providing services such as Medicines Use Reviews (MURs).

Pharmacy team members worked well together and spoke highly of each other. All team members spoken to confirmed they felt well supported by the pharmacy manager. And they had a good understanding of how to provide feedback and if needed escalate a concern. The pharmacy had a whistle blowing policy and a confidential help line where staff could seek support if required. The pharmacy team had an open approach to sharing feedback. And pharmacy team members provided some examples of how their ideas were trialled and reviewed. Those which worked well became

permanent and those which team members felt were not working were put back to the team for discussion. Recently the pharmacy team had trialled ideas relating to the management of the offsite dispensing workload.

The pharmacy had a structured appraisal process and a pharmacy team member provided some feedback on her most recent appraisal. This had focussed on individual competencies and learning and development. Pharmacy team members took part in regular discussions relating to patient safety and workload management. Patient safety was discussed throughout the month and recapped during the end of month patient safety review. The pharmacy received regular safety information from its head office in the form of 'Safe and Well' updates. These were displayed on a staff noticeboard along with a list of LASA medicines which team members were encouraged to add to. And pharmacy team members could discuss the shared learning following reading the updates.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is secure. It is clean and well 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 large and fitted with wide-spaced aisles. This provided full accessibility to people using wheelchairs and pushchairs. There was seating provided for people waiting for prescriptions or services. The pharmacy had a sign-posted consultation room to the side of the public area. This room allowed staff to maintain confidentiality when providing counselling about medicines or when holding private discussions with people. It was a sufficient size and equipped with the necessary resources to support pharmacy team members in delivering the pharmacy's services.

The pharmacy's prescription numbers had increased by around 35% since the last inspection in 2015. This had reduced workspace in the dispensary. And pharmacy team members demonstrated changes to the dispensing workflow they had implemented due to this. Further changes had been applied due to the change in working processes brought about by offsite dispensing. Workspace was effectively managed in the main dispensary. For example, pharmacy team members used most available space on work benches to manage their work. But work benches were free from excess clutter. Totes stored on the dispensary floor were pushed back against shelving to avoid trip hazards. Work associated with the multi-compartmental compliance pack service was managed in a back room off the dispensary. This room was of a good standard and provided good work space for this high-risk activity. To the side of this room was a small kitchen area. Staff facilities and a large store room were located off this area. The store room was kept in an orderly state.

The pharmacy had suitable heating arrangements. It received portable air conditioning units to help manage room temperature in summer months. But staff reported that the premises could still get very hot at times. A discussion took place about monitoring room temperature if any concerns arose. Lighting was sufficient throughout the premises. Pharmacy team members completed all cleaning tasks. And the pharmacy was generally clean. But the dispensary sink was worn through hardened limescale build-up. Pharmacy team members reported maintenance concerns to their head office. And confirmed responses were timely dependent upon the urgency of the matter.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy advertises its services and ensures these are accessible to people. The pharmacy team engages well with people through positively promoting services that support their health and wellbeing. And the pharmacy has considered the specific needs of the local community by offering the flu vaccination service for staff at a local school. The pharmacy obtains its medicines from reputable sources and it stores these securely. It has procedures to support its team in delivering services. And on the whole the team follow these.

Inspector's evidence

The pharmacy had two entrances at street level. It was located within a shopping area in the centre of town with free parking provided directly outside the pharmacy. The pharmacy advertised details of its opening times and services clearly. It also provided a good range of leaflets relating to services, chronic diseases and healthy living for people to take. The pharmacy was displaying promotional materials associated with the current national health campaign. And a dispenser explained how she would engage people in conversation about their health and wellbeing. The pharmacy had recently promoted and engaged in the National Autistic Society's 'Autism Hour' with other local businesses. This had involved organising and taking steps for an hour to promote a more autism-friendly world. Pharmacy team members explained many local people would visit the pharmacy in the first instance for advice and support. And they had a clear understanding of the requirement to signpost people to other healthcare services when needed.

The RP was extremely positive when discussing services. And beneficial outcomes from both MURs and the New Medicine Service (NMS) were provided. The pharmacist's commitment to providing quality pharmacy services had been recognised with a company award within the last year. The flu vaccination service was popular, with some 500 people vaccinated in the current season to date. The RP demonstrated how she had worked with a local school to provide flu vaccinations to staff onsite. Prior to the clinic the RP had undertaken a risk assessment of the environment, process and equipment required. And had sourced a portable cold unit to store the vaccinations. The service had been positively received.

The pharmacy had a 'health check' machine. This was located in a quiet corner of the public area. The machine gave people the opportunity to test their blood pressure and have their weight, body mass index and heart age recorded. Pharmacy team members explained the machine was very popular with local people, some of which would attend regularly to monitor their health. People could use the machine autonomously if preferred. But pharmacy team members were available to provide support. They explained how they often chatted to people about their health and wellbeing based on their readings. People were able to enter an email address into the machine and have the results sent directly to them. This allowed them to monitor their own health and provided opportunities for them to share their results with their GP or another healthcare professional.

The RP was discussing details of the NHS quality criteria lithium audit as the inspection process began. And the pharmacy was part way through this audit. It engaged regularly in audits associated with the NHS Quality Scheme. For example, a valproate safety audit. And a diabetic eye and foot check audit.

Results of the diabetic eye and foot check audit had resulted in referrals as some people had not received a foot check within the last 12 months. The pharmacy had systems to identify high-risk medicines. And the RP demonstrated how formal records of checks associated with these medicines were kept. The pharmacy had the tools required to comply with the valproate pregnancy prevention programme (PPP). High-risk warning cards and information leaflets were stored with sodium valproate preparations in the dispensary. And the RP demonstrated how prescribers also recorded information relating to the PPP on prescription forms for people in the high-risk group. The RP felt that the pharmacy had a good working relationship with local surgeries. For example, surgeries managed referrals from the pharmacist vigilantly. And the RP frequently updated surgeries of manufacturing issues with medicines and suggested suitable alternatives. For example, information about the availability of hormone replacement therapy products had been provided to local surgeries.

The team had completed training and competency tests prior to sending prescriptions to the company's hub as part of its central fulfilment service. Workflow and risks associated with this service were managed appropriately. Pharmacy team members discussed and demonstrated how they had recently reviewed and improved upon the processes they applied to manage the service. They had done this through following the company's 'Best in Class' guidance. This was a tool designed to support teams in following SOPs and managing risks when delivering the pharmacy's services. Random 'Post-hub' checks were also in place. This required the pharmacist to physically check three hub dispensed prescriptions daily. An audit trail of these post-hub checks was maintained. And the RP confirmed no mistakes had been found to date. 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 packet 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-compartmental compliance pack service across a four-week rolling rota. It had recently started a review of its processes for managing this service. Individual profile sheets were in place for each person on the service. And pharmacy team members were in the early stages of updating these sheets to ensure all information contained on them remained clear and easy to read. The profile sheets did not routinely include formulations of the medicines inside the packs. And although medication changes were checked and confirmed before being applied. The pharmacy team did not regularly provide tracked details of these changes on the profile sheets. A pharmacy team member demonstrated new medication event records which were being incorporated to support team members in recording this information. A sample of assembled packs did not contain dispensing audit trails. The RP explained that one member of the team assembled packs each week. She recognised although she would be aware of who had assembled the pack, people receiving the packs would not have the assurance that two members of the team had been involved in the dispensing process if an audit trail was not provided. The pharmacy provided descriptions of the medicines inside the pack to help people identify them. It supplied patient information leaflets for new medicines. But not routinely at the beginning of each four-week cycle of packs. The requirement to supply a patient information leaflet each time a medicine was dispensed was discussed. Pharmacy team members did not secure backing sheets to packs. A discussion took place about the risks associated with not securing these sheets in a safe manner. And pharmacy team members confirmed the sheets would be attached moving forward.

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. People were asked to sign for receipt of their medicines through the service.

The pharmacy sourced medicines from licensed wholesalers and specials manufacturers. Its clinical computer system had been updated in July 2019. 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 learning associated with FMD and the RP demonstrated how medicines in FMD compliant packaging were checked during the dispensing process to ensure the tamper proof seals had not been broken. The pharmacy team received drug recalls and alerts electronically. They responded to these and maintained a local copy for reference purposes. Drug recalls and alerts were also documented on the monthly patient safety review.

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. Most medicines were stored on shelves in their original packaging. A couple of white boxes containing medicines were also stored with original packs. Pharmacy team members explained these medicines had not been collected and so returned to stock. Most details of the medicine inside the box were recorded on an attached label. But the team did not always annotate the batch number or expiry date onto the white box to help support stock management checks. Some medicines held in baskets waiting to fill multi-compartmental compliance packs had been de-blistered and returned loose into their original box. A dispenser explained this was done the day before a pack was assembled to help manage time associated with assembling packs. A discussion took place about the risks associated with de-blistering medicines ahead of them being required to fill packs. And the RP confirmed this practice would stop.

The pharmacy team followed a date checking rota to help manage stock and it recorded details of the date checks it completed regularly. Short-dated medicines were identified and the team generally annotated details of opening dates on bottles of liquid medicines. Opening dates were not recorded on bottles of methadone within the CD cabinets. A check of the register confirmed the pharmacy were using each bottle well in advance of its shortened expiry date once opened. 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 held CDs in secure cabinets. Medicine storage inside the cabinets was orderly. There was designated space for storing patient returned, and out-of-date CDs. 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 had three medical fridges. They were clean and medicines inside were stored in an organised manner. Assembled medicines were stored in clear bags which prompted additional checks prior to hand out. The pharmacy team monitored fridge temperatures. But the maximum temperature of one of the fridges had been reading nine degrees Celsius for a couple of weeks. The minimum temperature during this time had remained at two degrees Celsius. It was not known if the thermometer had been reset. This was done during the inspection and the fridge remained within the required temperature range throughout the inspection. The RP confirmed she would monitor this and address the concern with the team as the heightened maximum temperature had not been brought to her attention prior to the inspection.

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 manage and use this 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. 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 pharmacy stored assembled bags of medicines to the side of the dispensary and medicine counter. Pharmacy team members used NHS smart cards to access people's medication records. But not every member the team had a smart card. They used a cordless telephone handset. This helped to protect people's confidentiality as the pharmacy team member was 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, including a separate counting triangle for use when counting cytotoxic medicines. And a set of dispensary scales were checked for accuracy prior to each use. Pharmacy team members had access to appropriate equipment for assembling medicines in multi-compartmental compliance packs. For example, single-use packs and disposable gloves. And equipment to support the flu vaccination service was readily available. For example, anaphylaxis supplies.

The pharmacy's electrical equipment had been safety checked in January 2019. But one of the two installed hearing loops had not passed this check and was not in working order. The manager confirmed she would chase this matter up as priority. The pharmacy had a service contract for its health check machine. And a dispenser confirmed the machine had been checked a few months ago by a visiting contractor.

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.