General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Well, New Surgery, Port Road Industrial Estate, CARLISLE, Cumbria, CA2 7AJ

Pharmacy reference: 1074833

Type of pharmacy: Community

Date of inspection: 21/02/2020

Pharmacy context

This is a community pharmacy in a medical centre in Carlisle, Cumbria. It dispenses both NHS and private prescriptions and sells a range of over-the-counter medicines. The pharmacy team offers advice to people about minor illnesses and long-term conditions through its NHS services. And it provides a home delivery service.

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 has an up-to-date set of procedures to identify and manage risks to its services. The pharmacy's team members follow them to make sure they work safely and effectively. The pharmacy mostly keeps the records it must have by law. And it keeps people's private information secure. The team members know when and how to raise a concern to safeguard the welfare of vulnerable adults and children. The pharmacist records and analyses mistakes that happen within the dispensing process. And they take some steps to reduce the risk of similar mistakes happening again.

Inspector's evidence

The pharmacy had an open plan dispensary and retail area. The pharmacy counter acted as a barrier between the retail area and the dispensary to prevent any unauthorised access. The pharmacist used the bench closest to the retail area to complete final checks on prescriptions. And so, she could listen in to conversations the pharmacy's team members were having with people.

The pharmacy had a set of up-to-date electronic standard operating instructions (SOPs) in place. The superintendent pharmacist's office reviewed the procedure every two years on a monthly rolling cycle. It sent new and updated procedures to pharmacy team members via the eExpert online training system approximately each month. Once the team members had read the contents of the SOP, they needed to complete a short quiz to test their understanding. They had to pass the quiz to be signed of as having read and understood the SOP. A team member demonstrated their training records. And they were mostly up to date. The pharmacy defined the roles of the pharmacy team members in each procedure. Which made clear the roles and responsibilities within the team.

The pharmacist highlighted any near miss errors made by the team when dispensing. Once the error was rectified, the pharmacist made an entry of the near miss onto a paper near miss log. The other team members were not involved in the recording of near miss errors. The pharmacist recorded the time and the date of the near miss error. But didn't record the reason why the error had happened, or the action taken to reduce the risk of the error happening again. The pharmacist entered the details of the near misses onto an online reporting system called Datix. The system created a monthly report which was kept electronically. The team members demonstrated a recent report. The report focused on reducing the number of near miss errors involving medicines that looked or sounded similar, known as LASA medicines. The team members explained they had decided to affix some shelf edge alert stickers next to where they stored some LASAs medicines. The purpose of the alert stickers was to remind the team to take more care when they were picking the LASA medicines from the shelves. But many of the stickers had been removed over time and not been replaced. The pharmacy had a process for dealing with dispensing errors that had been given out to people. It recorded incidents on the Datix system. The pharmacy had recently supplied a person with phenytoin capsules instead of tablets. The team members discussed ways they could stop a similar error happening again. They decided to separate the tablets and capsules away from each other.

The pharmacy was displaying the correct responsible pharmacist notice at the time of the inspection. The team members explained their roles and responsibilities. And they were seen working within the scope of their role throughout the inspection. The team members accurately described the tasks they could and couldn't do in the absence of a responsible pharmacist. For example, they explained how

they could only hand out dispensed medicines or sell any pharmacy medicines under the supervision of a responsible pharmacist.

The pharmacy had a formal complaints procedure. But it wasn't on display in the retail area for people to see. People who used the pharmacy could discuss any concerns or complaints they had with any of the team members. And if the problem could not be resolved, it would be escalated to the pharmacy's superintendent pharmacist's team. The pharmacy collected feedback each year through questionnaires that were placed on the pharmacy counter for people to self-select and complete. The team members explained the results were generally positive and they were not aware of people identifying any significant areas of practice they wanted the pharmacy to improve in.

The pharmacy had up-to-date professional indemnity insurance. Entries in the responsible pharmacist record complied with legal requirements. The pharmacy kept records of private prescriptions but three of the last four entries were not completed according to requirements as the date the prescription was issued was not recorded. The pharmacy kept complete records of emergency supplies. It kept controlled drugs (CDs) registers. And they were completed correctly. A physical balance check of a randomly selected CD matched the balance in the register. The team completed a full balance check of the CDs every week. The pharmacy kept complete records of CDs returned by people to the pharmacy. The pharmacy held certificates of conformity for unlicensed medicines, but they weren't always completed in line with the requirements of the Medicines & Healthcare products Regulatory Agency (MHRA). For example, some certificates did not include the details of the prescriber.

The pharmacy outlined how it handled personal and sensitive data through a privacy notice in the retail area. The team members had undertaken training on General Data Protection Regulation (GDPR). And they had completed training each year via the eExpert online training system. They were aware of the need to keep people's personal information confidential. The team held records containing personal identifiable information in areas of the pharmacy that only team members could access. Confidential waste was placed into a separate bin to avoid a mix up with general waste. The confidential waste was periodically collected by a third-party contractor and securely destroyed.

The responsible pharmacist had completed training on safeguarding vulnerable adults and children through the Centre for Pharmacy Postgraduate Education (CPPE). Other team members had not completed any formal training. When asked about safeguarding, the team members gave several examples of the symptoms that would raise their concerns in both children and vulnerable adults. A team member explained how she would discuss her concerns with the pharmacist on duty, at the earliest opportunity. There was written guidance kept in the dispensary. And there were blank safeguarding information reporting forms. If the team members needed further guidance, they explained they would contact the pharmacy's superintendent pharmacist's office for support.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy team members have the appropriate qualifications and skills to provide the pharmacy's services safely and effectively. They work well together to manage their workload. The pharmacy team members complete training relevant to their role, to keep their knowledge and skills up to date. They can make suggestions to improve the pharmacy's services. And they feel comfortable to raise professional concerns if necessary.

Inspector's evidence

The responsible pharmacist at the time of the inspection was the pharmacy's full-time resident pharmacist. A part-time trainee pharmacy assistant and a relief pharmacy assistant supported her. The pharmacy also employed a full-time pharmacy assistant who was the pharmacy's manager and another part-time pharmacy assistant. The manager was absent during the inspection and the relief pharmacy assistant was working to cover the absence. The team members often worked additional hours to cover absences and holidays. The team was seen managing the workload well and dispensing prescriptions in a timely manner. The team members supported each other and were seen asking the pharmacist for support, especially when presented with a query for the purchase of an over-the-counter medicine. The pharmacy had undergone a recent reduction in hours. The pharmacist felt the pharmacy had enough staff to manage the workload well particularly since the pharmacy had started using the company's offsite dispensing hub. This had reduced the team's dispensing workload, and around half of the pharmacy's prescriptions were now being dispensed at the hub.

The pharmacy provided the team members with a structured training programme. The programme involved team members completing various e-learning modules through the eExpert online system. The modules covered various topics including health and safety, new and revised SOPs and health conditions such as pain relief. Some modules were mandatory and some could be chosen voluntarily in response to an identified training need. The team members received protected training time during the working day to complete the modules. So, they could do so without any distractions. But they weren't always able to take the time. The trainee pharmacy assistant was enrolled on a Buttercups training course. She was scheduled to receive protected training time each week. But she hadn't been able to take the time in recent weeks due to staff holidays and absences.

The team members felt comfortable to raise professional concerns with pharmacist, the pharmacy manager or the pharmacy's regional development manager. The manager had recently asked the regional development manager for extra staffing support. The regional development manager planned for the pharmacy to have additional relief dispenser cover every Thursday. The pharmacy had a whistleblowing policy. So, the team members could raise concerns anonymously. They were encouraged to give feedback to improve the pharmacy's services. but no examples were provided. The pharmacy set the team various targets to achieve. These included the number of prescription items dispensed and the number of services provided. The targets did not impact on the ability of the team to make professional judgements.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean, hygienic and properly maintained. It provides a suitable space for the health services provided. And the pharmacy has a room where people can speak privately to the pharmacy's team members. But it is not regularly offered to people to use.

Inspector's evidence

The pharmacy was clean and professional in its appearance. There was signage which clearly identified to people there was a pharmacy inside the building. The dispensary was kept tidy and well organised during the inspection and the team used the bench space well to organise the workflow. Floor spaces were generally kept clear to minimise the risk of trips and falls, but there were some boxes of miscellaneous items at the back of the dispensary. There was a clean, well-maintained sink in the dispensary for medicines preparation and staff use. There was a toilet with a sink with hot and cold running water and other facilities for hand washing.

The retail area was small. During the inspection there were often several people stood or sat down in the retail area while they waited for their prescriptions to be dispensed. The team members were observed talking with people about their medicines and their health when other people were stood close by. So, there was a risk that other people could hear people's personal information. There were seats available for people to sit down. But the cushions were ripped, and this did not portray a professional image.

The pharmacy had a sound-proofed consultation room with seats where people could sit down with the team member to have a private conversation. The team members were not seen to be offering the use of the room to people. The room was smart and professional in appearance and was signposted by a sign on the door. The temperature was comfortable throughout the inspection. Lighting was bright throughout the premises.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's services are easily accessible to people. The pharmacy manages its services appropriately and delivers them safely. And it uses an offsite pharmacy dispensing hub to help manage the dispensing workload more effectively. The pharmacy obtains its medicines from reputable sources. And it stores and mostly manages its medicines safely and securely.

Inspector's evidence

The pharmacy had level access from the health centre car park. So, people with pushchairs or wheelchairs could easily enter the building. The pharmacy advertised its services and opening hours in main window. And there were several healthcare related leaflets available for people to select and take away with them. The team members had internet access. They could use the internet to signpost people to other pharmacies or healthcare providers if they were unable to provide a service. There was a 'healthy living zone' in the retail area. The area was used to promote awareness about various healthcare related topics. The zone was displaying a poster advertising free tests for 15-24-year olds for gonorrhoea and chlamydia. There was a hearing loop for people with hearing aids to use. And the pharmacy could provide large print labels to help people who had a visual impairment.

The team members regularly used various stickers that they could use as an alert before they handed out medicines to people. For example, to highlight interactions between medicines or the presence of a fridge line or a controlled drug that needed handing out at the same time. The team members signed the dispensing labels to indicate who had dispensed and checked the medication. And so, a robust audit trail was in place. Baskets were available to hold prescriptions and medicines to help manage the workflow efficiently. And they were of different colours to help the team separate different parts of the dispensing workload. For example, blue baskets were used for prescriptions for home delivery. The pharmacy did not offer to dispense people's medicines in multi-compartment compliance packs. This was because of the lack of space in the dispensary to safely provide the service. The team members explained they signposted people to another local Well pharmacy if they wanted their medicines dispensed in the packs. The team had a robust process to highlight the expiry date of CD prescriptions awaiting collection in the retrieval area. The team members gave people owing slips when the they could not supply the full prescribed quantity. One slip was given to the person. And one kept with the original prescription for reference when the remaining quantity was dispensed and checked. The team attempted to complete the owing the next day. The pharmacy kept records of the delivery of medicines from the pharmacy to people. The records included a signature of receipt. So, there was an audit trail that could be used to solve any queries. A note was posted to people when a delivery could not be completed. The note advised them to contact the pharmacy.

The pharmacy had introduced a new system for dispensing many of the prescriptions it received, at the company's offsite dispensing hub. The system was designed to reduce the team's dispensing workload and allow the team members more time to offer services such as flu vaccinations. The team members could not evidence how they made people aware their medicines were dispensed away from the pharmacy. The importance of ensuring they received people's consent for their medicines to be dispensed at the hub was discussed with the team. Each team member had received comprehensive training before the process went live. The team firstly assessed whether a prescription was suitable to be dispensed at the hub. Any prescriptions that were for CDs or fridge items were not sent. The team

also avoided sending prescriptions for more urgent items such as antibiotics. Once it was established that a prescription was suitable to be sent to the hub, the data was entered. And then the pharmacist completed an accuracy and clinical check. Only the pharmacist, using their personal smart card and password, was able to perform the clinical and accuracy check and release prescriptions to the hub. Each item on the prescription was marked with an 'H' if it was to be dispensed at the hub. On occasions, not every item on a prescription was dispensed at the hub. If any items on a prescription were not dispensed at the hub, they were marked with an 'L' which indicated the items were dispensed 'locally'. The prescription was assembled using automation at the hub. It took around two or three days for prescriptions to be processed and the medicines to be received from the hub. The team marked all prescriptions that were sent to the hub and stored them in a separate box to prevent them being mixed up with other prescriptions. The pharmacy received the medicines that had been dispensed at the hub in sealed bags. The bags were then coupled with the relevant prescription. And then scanned on the shelves in the prescription retrieval area, ready for collection. Each day the pharmacist opened three randomly selected bags that had been dispensed at the hub and completed another accuracy check. This was to ensure the pharmacy completed a regular quality check.

The pharmacy dispensed high-risk medicines for people such as warfarin. The team members used 'therapy check' or 'speak to pharmacist' stickers attached to people's medication bags to remind the person handing out that the bag contained a high-risk medicine. But they didn't always use the stickers. So, some people may have not had the appropriate checks completed. The pharmacist did some basic checks with people who were identified as taking a high-risk medicines when they came to collect their medicines. These included ensuring the person was aware they had to take methotrexate weekly and checked their current and target INR if they were prescribed warfarin. The team members were aware of the pregnancy prevention programme for people who were prescribed valproate and of the risks. But they did not have all the tools available to them to comply with the programme. For example, patient guide booklets and alert cards. The team had completed a check to see if any of the pharmacy's regular patients were prescribed valproate. And met the requirements of the programme. No one had been identified.

The pharmacy provided a repeat prescription ordering service. The pharmacy ordered used cards to note down each medicine a person could order on a repeat prescription from their GP. And the person was asked which medicines they wanted to order each time they were due for their repeat prescription. This helped prevent people ordering medicines people did not need. The team members kept records of the medicines that were ordered. And the records were cross-referenced with the prescriptions to make sure they were accurate. Once the medicines had been dispensed, the team members used a text messaging service to inform the patient that their medicines were ready to be collected.

Pharmacy medicines (P) were stored behind the pharmacy counter. So, the pharmacist could supervise sales appropriately. The medicines in the dispensary were tidily stored. Every three months, the team members checked the expiry dates of its medicines to make sure none had expired. And the team was up to date with the process. But two out-of-date medicines were found following a check of around thirty randomly selected medicines. The two medicines had a 'use this pack first' sticker attached to them. The stickers prompted the team members to check the expiry date of the medicine during the dispensing process. They recorded the date liquid medicines were opened on the pack. So, they could check they were in date and safe to supply. The pharmacy had a robust procedure in place to appropriately store and then destroy medicines that had been returned by people.

The team was not currently scanning products or undertaking manual checks of tamper evident seals on packs, as required under the Falsified Medicines Directive (FMD). The team had received some training on how to follow the directive. The team members were unsure of when they were to start

following the directive. Drug alerts were received via email to the pharmacy and actioned. The alerts were printed and stored in a folder. And the team kept a record of the action it had taken. The pharmacy checked and recorded the fridge temperature ranges every day. And a sample checked were within the correct ranges. The CD cabinets were secured and of an appropriate size. The medicines inside the fridge and CD cabinets were well organised.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy's equipment is well maintained and appropriate for the services it provides. The pharmacy uses its equipment to protect people's confidentiality.

Inspector's evidence

The pharmacy had reference resources including copies of the BNF and the BNF for children for the team to use. And the team had access to the internet as an additional resource. The pharmacy used a range of CE quality marked measuring cylinders. The fridges used to store medicines were of an appropriate size. Prescription medication waiting to be collected was stored in a way that prevented people's confidential information being seen by members of the public. And computer screens were positioned to ensure confidential information wasn't seen by unauthorised people. The computers were password protected to prevent any unauthorised access. The pharmacy had cordless phones, so the team members could have conversations with people in private.

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.