General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Weldricks Pharmacy, 35 Grange Lane, Rossington, DONCASTER, South Yorkshire, DN11 0LW

Pharmacy reference: 1075375

Type of pharmacy: Community

Date of inspection: 06/06/2019

Pharmacy context

The pharmacy is opposite a medical centre, in an ex-mining village.
The pharmacy sells over-the-counter medicines and dispenses NHS 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	1.2	Good practice	Pharmacy team members act openly and honestly by sharing information when mistakes happen. They engage fully in shared learning processes to help reduce identified risks.
		1.4	Good practice	The pharmacy advertises how people can provide feedback. And its team actively ask for feedback. It responds well to people who choose to provide feedback by using the information provided to inform delivery of its services.
2. Staff	Good practice	2.2	Good practice	The pharmacy has good systems in place for supporting its team members development through continual learning and structured appraisals.
		2.4	Good practice	Pharmacy team members demonstrate how they are open to learning and they work together well.
		2.5	Good practice	The pharmacy encourages its team members to seek support and to provide feedback. And it uses this feedback to inform the safe management of its services.
3. Premises	Standards met	3.2	Good practice	The pharmacy's consultation room is fully accessible to people wanting a private conversation with a member of the team. And the team is good at actively promoting access to the room.
4. Services, including medicines management	Standards met	4.1	Good practice	The pharmacy reaches out to people in the local community to promote its services and to encourage healthy living and wellbeing.
		4.2	Good practice	The pharmacy has good records and systems in place to make sure people get the right medicines at the right time. And it demonstrates beneficial outcomes from the services it provides.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance ✔ Standards met

Summary findings

The pharmacy has appropriate systems to identify and manage the risks associated with the services it delivers. It generally keeps all records it must by law. But some gaps in these records occasionally result in inaccurate and incomplete audit trails. The pharmacy manages people's private information securely. The pharmacy advertises how people can provide feedback about its services. And its team actively ask for feedback. It uses this feedback to inform delivery of its services. Pharmacy team members act openly and honestly by sharing information when mistakes happen. They engage fully in shared learning processes to help reduce identified risks. Pharmacy team members have a clear understanding of how to safeguard vulnerable people.

Inspector's evidence

The pharmacy had a set of standard operating procedures (SOPs) in place. SOPs had last been updated prior to electronic versions being made available to the team in 2018. But details of these reviews were not recorded on all SOPs. Some information in SOPs required updating. This was due to a change in the clinical software used by the pharmacy which had introduced different ways of recording information on people's medication records. Roles and responsibilities of the pharmacy team were set out within SOPs. A sample of training records confirmed that members of the team had completed training associated with SOPs relevant to their roles. Pharmacy team members on duty were seen working in accordance with dispensing SOPs. A trainee member of the team clearly explained that a pharmacy (P) medicine could not be sold if the responsible pharmacist (RP) was absent from the premises. She explained that if she was asked to hand-out an assembled medicine during RP absence, she would check with another member of the team first. Another pharmacy team member confirmed that assembled medicines could not be handed out if the RP was absent from the premises. The regular pharmacist did not routinely take absence from the pharmacy.

A dispenser undertook the role of accuracy checking assistant (ACA). Another dispenser had also commenced training for this role. The ACA maintained details of her training and a statement provided by senior management relating to her role within the pharmacy. Procedures were in place to support this role. She explained how she maintained her competencies through recording and reflecting on near-misses she identified during the checking process. She was also supported with six-monhtly one-to-one reviews with the pharmacy manager. Pharmacists physically recorded the completion of clinical checks on prescription forms prior to the ACA completing the final accuracy check of a medicine.

Workflow was organised with separate work bench space used for managing acute prescriptions for people waiting in the pharmacy and for repeat prescriptions. Pharmacist's and the ACA had protected space for completing accuracy checks of medicines. Pharmacy team members physically marked prescription forms during the labelling process to highlight new medicines to the pharmacist clinically checking the prescription. This also informed counselling upon hand-out to the person.

There was a near-miss reporting procedure in place. Pharmacy team members demonstrated consistent reporting. They explained how feedback from the accuracy checker was provided at the time the near-miss took place. They recorded their own near misses and corrected their own near-misses whenever possible. Near-misses had risen following the pharmacy's change to a new clinical software programme. This rise had prompted additional discussions and learning points as the team familiarised themselves

with the new system.

The pharmacy manager completed monthly trend analysis reviews of near-misses. Results of the trend analysis exercise was shared with the team either in formal staff meetings held out of hours or in small groups during the working day, if a staff meeting could not be arranged. Pharmacy team members demonstrated how they implemented risk reduction actions following these shared learning opportunities. For example, each strength of pregabalin was stored in individual, clearly labelled baskets on the dispensary shelves. The team explained that this had been successful in prompting additional checks when picking pregabalin during the dispensing process. The team also demonstrated how they identified and shared learning relating to 'look alike and sound alike' (LASA) medicines to reduce the risk of selecting the wrong medicine.

The pharmacy reported dispensing incidents electronically to the superintendent's team. Records made included completion of a risk matrix, route cause analysis, learning points and actions taken to reduce a similar event occurring. The RP, who was the pharmacy manager, demonstrated how the report was updated following shared learning and actions being implemented. For example, amlodipine and amitriptyline had been separated on the dispensary shelves following a dispensing incident. There was evidence of the pharmacy sharing learning from the error with the prescriber, after the time of the dose on a prescription was identified as a contributing factor to the incident.

The pharmacy had a complaints procedure in place and forms were used to record serious concerns which required escalation to the pharmacy's superintendent pharmacist. A practice leaflet advertised how people could provide feedback to the pharmacy team. It also provided details about how the pharmacy safeguarding people's private information. A member of the team confidently explained how she would manage feedback and look to resolve it or escalate it if needed to the manager or supervisor if needed. The pharmacy displayed the results of their annual 'Community Pharmacy Patient Questionnaire'. And pharmacy team members explained how this feedback was used to inform service delivery. For example, a partial re-fit of the pharmacy had allowed the team to improve the efficiency of the dispensing service. A member of the team was observed asking people using the pharmacy's repeat prescription smart phone application how they were finding it. The team explained that this feedback helped inform how staff used the application to communicate with people.

The pharmacy had up to date indemnity insurance arrangements in place.

The RP notice displayed the correct details of the RP on duty. Entries in the responsible pharmacist record followed legal requirements.

A sample of the CD register found that it met legal requirements. The pharmacy kept running balances in the register. The pharmacy recorded balance checks of the register against physical stock monthly. Stock checks also took place upon receipt and hand-out of CDs. Physical balance checks of CDs carried out as part of the inspection complied with the balances in the register. A CD destruction register for patient returned medicines was maintained to date. The team entered returns in the register on the date of receipt. The pharmacy had some returns waiting to be denatured at the time of inspection.

The pharmacy held the Prescription Only Medicine (POM) register electronically. Records generally complied with legal requirements. But the details of the prescriber in some entries was not always recorded accurately. The pharmacy team kept records within the register of some emergency supplies dispensed. But some supplies made through the Pharmacy Urgent Repeat Medicine (PURM) were not seen to be entered in the POM register as required.

The inspection revealed that there had been a misunderstanding of the need to maintain full audit trails

on certificates of conformity for unlicensed medicines following the local NHS Clinical Commissioning Group no longer requiring a copy of the certificate. A discussion took place about the requirements of maintaining a record in accordance with Medicines and Healthcare Products Regulatory Agency (MHRA) requirements. The RP confirmed that the pharmacy team would work to bring records up to date and maintain them moving forward.

The team held records containing personal identifiable information in staff only areas of the pharmacy. It had completed learning following the introduction of the General Data Protection Regulation (GDPR). The pharmacy had submitted its annual NHS Information Governance toolkit as required. The latest internal information governance audit had been completed in December 2018. These had previously been completed quarterly and had provided the team with an opportunity to regularly test their understanding of data protection requirements. The pharmacy team transferred confidential waste to white sacks. Sacks were secured and collected for secure destruction periodically.

The pharmacy had procedures relating to safeguarding vulnerable adults and children and a chaperone policy was in place. The team had access to contact details for local safeguarding teams. Most pharmacy team members had completed learning relating to safeguarding. Pharmacists and the pharmacy technicians had completed level 2 training on the subject. Pharmacy team members discussed how they worked to recognise, and report concerns about vulnerable individuals.

Principle 2 - Staffing ✔ Good practice

Summary findings

The pharmacy has enough skilled and knowledgeable people to provide its services. It has good systems in place for supporting its team members development through continual learning and structured appraisals. The pharmacy encourages its team members to seek support and to provide feedback. And it uses this feedback to inform the safe management of its services. Pharmacy team members engage in regular meetings to share learning and to identify and reduce risks associated with delivering the pharmacy's services. They demonstrate how they are open to learning following their own mistakes and they work together well.

Inspector's evidence

On duty at the time of the inspection was the RP (the pharmacy manager), a relief pharmacist, a pharmacy technician, the ACA, a qualified dispenser and two trainee dispensers. The pharmacy employed another trainee dispenser, a medicine counter assistant and two more qualified dispensers, one of which was the pharmacy's supervisor. A company employed delivery driver provided the prescription delivery service. A second pharmacist usually worked one to two days per week in the pharmacy.

The pharmacy kept training records for its team. Trainee dispensers began work on the medicine counter and concentrated on training relevant to this role prior to moving into the dispensary. The manager explained how this approach helped to ensure staff were progressing in their roles without overwhelming them. Trainees on duty at the time of inspection confirmed they felt supported by the whole team and received regular training time. The pharmacy encouraged all its team members to complete continual learning to help keep their knowledge and skills up to date. Training over the last 12 months had included participation in the Centre for Pharmacy Postgraduate Education (CPPE) risk management course, a women's health kit and safeguarding training. Each member of the team received an annual appraisal. Team members were asked to reflect on their performance and development prior to the face-to-face meeting with their manager.

The pharmacy had some targets in place. These included targets for Medicine Use Reviews (MURs) and New Medicines Services (NMS). Both pharmacists agreed that there was an increasing emphasis on the need to meet targets since the funding cuts to pharmacy. The RP explained that pharmacy professionals were encouraged to seek support if they felt they were struggling with the targets. The pharmacists discussed how they applied their professional judgement when undertaking services and clearly enjoyed speaking to people about their medicines.

The pharmacy maintained notes from out-of-hour staff meetings. This meant if a member of the team could not attend, the learning from the meeting could be shared. Pharmacy team members explained that information was shared with them during small group discussions on a continual basis. Full staff meetings recapped important information. And the meetings were used by the team as an opportunity to review and expand on learning following mistakes made during the dispensing process. Topics discussed in recent meetings included the Falsified Medicine Directive (FMD), GDPR and the pharmacy's repeat prescription application.

There was a whistle blowing policy in place. Pharmacy team members confirmed their understanding of

how to raise concerns with their supervisor or manager in the first instance. They could explain how they would escalate a concern if required. Pharmacy team members explained they were encouraged to provide feedback and to raise any concerns they had. Pharmacy team members worked well together and were receptive to each other's feedback. They provided examples of how their feedback was listened to and used to inform service delivery. For example, team briefings were used to inform learning and proficient use of the pharmacy's repeat prescription application. This has resulted in recognition from the company about the number of people actively using the application.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean and secure. It provides a professional environment for the delivery of its services. The pharmacy's consultation room is fully accessible to people wanting a private conversation with a member of the team. And the team is good at promoting access to the room.

Inspector's evidence

The pharmacy was professional in appearance and it was secure. The public area was open plan which allowed easy access for people using wheelchairs and pushchairs. Pharmacy team members explained that maintenance concerns would be reported to the pharmacy's head office. There were no outstanding maintenance issues at the time of inspection. The pharmacy was clean and organised with no slip or trip hazards evident. Air conditioning was in place. Lighting throughout the premises was sufficient. Antibacterial soap and paper towels were available close to designated handwashing sinks.

The pharmacy had benefitted from a partial re-fit earlier in the year. Pharmacy team members demonstrated how this had created more space and had led to a more effective workflow, particularly for managing tasks associated with supervised consumption and accuracy checking. A back room, off the dispensary held stock medicines and provided access to the dispensary sink. Work benches in this room were largely utilised to complete administration tasks and tasks associated with the prescription delivery service. The dispensary was a suitable size for the workload the pharmacy received. But multi-compartmental compliance packs were dispensed on a busy work bench in the main dispensary. The member of the team assembling packs at the time of inspection was disturbed several times during the process due to other team members requiring access to the area. A discussion took place about the advantages of utilising quieter space in the pharmacy to assemble the packs. The pharmacy had recognised space as a risk and as such another local branch dispensed some packs to people wanting to access this service. Staff facilities and a kitchen/store room were also accessible on the ground-floor level of the premises. The first-floor level of the premises was relatively empty, the pharmacy stored archived records here.

There was a private consultation room to the side of the dispensary. Both the public door and dispensary door to the room were fitted with code combination locks. The public door remained unlocked unless the room was in use to promote access. The dispensary door remained secure to prevent unauthorised access into the dispensary. All equipment in the room was stored in a locked cupboard. A hatch from the room led to the dispensary. This provided people accessing the supervised consumption service with privacy. Pharmacy team members promoted access to the room well.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy promotes its services and makes them fully accessible to people. It reaches out to people in the local community to promote pharmacy services and to encourage healthy living and wellbeing. The pharmacy has good records and systems in place to make sure people get the right medicines at the right time. And it demonstrates beneficial outcomes for people, from the services it provides. The pharmacy gets its medicines from reputable sources. And it generally stores and manages them appropriately to help make sure they are safe to use. It has systems in place to provide assurance that medicines are fit for purpose.

Inspector's evidence

The pharmacy had a push/pull door at street level. A clearly sign-posted bell was in place to help alert staff when people required assistance with access into the pharmacy. Opening times and details of the pharmacy's services were advertised. There was a range of service and health information leaflets available for people to take. These were located close to a healthy living promotional display in the public area of the pharmacy. Pharmacy team members explained how they would signpost people to another pharmacy or healthcare provider if they were unable to provide a service. Designated seating was available for people waiting for a prescription or service.

The RP explained that she enjoyed delivering services. And pharmacy team members helped to identify eligible people for MURs and NMS services during the dispensing process. The RP reflected on some positive examples from the services provided. Outcomes from the NMS service included recognising side effects of medicines and monitoring these during the first few weeks of people commencing on a new medicine. Persistent side effects resulted in interventions and advice for people to book a review with their GP for an alternative medicine to be considered.

The pharmacy was participating in a pilot scheme to deliver an NHS health check service for people aged 40 to 74. The service had resulted in an inundated number of referrals. This had led the team to review clinic time required for the service, to ensure it remained accessible but did not impact on access to the pharmacy's other services taking place in the consultation room. Around 10 people per week visited the pharmacy to access the health check service. The team member providing the service was extremely passionate about promoting healthy living. She explained how she reviewed people's diets and lifestyles with them to try and help identify contributory factors if results were not within healthy levels. And she promoted using the food labelling traffic light system as a way for people to monitor their fat, sugar and salt intake. The same member of the team was also the pharmacy's smoking cessation advisor. Uptake rates for the service were good, as were the number of quits achieved. The pharmacy had won several awards over recent years for their high quit rate.

The pharmacy team had used the recent surgery open day to help promote access to pharmacy. For example, details of the minor ailments scheme were shared with people. The pharmacy had an up to date protocol in place for this service. And it held up to date and legally valid Patient Group Directions for the supply of varenicline tablets as part of the smoking cessation service and for emergency hormonal contraception.

The pharmacy had processes in place to identify people taking high-risk medicines. The team was familiar with the requirements of the 'Valproate Pregnancy Prevention Programme' (VPPP). And the RP

had recorded counselling and details of pregnancy prevention plan checks on people's medication records. The pharmacy had completed a valproate audit in 2018. Valproate warning cards were not available at the time of inspection. A discussion took place about the need to issue a warning card every time a prescription for valproate was dispensed to a female within the VPPP target group. There was evidence of some monitoring checks being recorded on people's medication records after verbal counselling relating to other high-risk medicines was given. The pharmacy had some support materials available to people. For example, steroid warning cards and methotrexate monitoring records. CDs were clearly identified. This helped prompt additional safety checks at the point of hand-out.

The pharmacy used coloured baskets throughout the dispensing process. This kept medicines with the correct prescription form and helped to inform workload priority. Pharmacy team members signed the 'dispensed by' and 'checked by' boxes on medicine labels to form a dispensing audit trail. They also completed relevant sections of 'Quad grids' on prescription forms. These grids showed who had taken in, labelled, assembled and accuracy checked the prescription. A random check of prescription forms found all sections of the grid completed. The pharmacy team kept original prescriptions for medicines owing to people. The prescription was used throughout the dispensing process when the medicine was later supplied. It kept delivery audit trails for the prescription delivery service. People were asked to sign at the point of delivery to confirm they had received their medicine.

A robust audit trail was in place to support the repeat prescription ordering and collection service. Checks were in place to identify missing prescriptions and changes to medicine regimens. And these were managed as priority queries to avoid the risk of a person being without medicine. Every person receiving a multi-compartmental compliance pack had a profile sheet in place. A four-week schedule was in place which spread workload across the month. Details of changes to medicine regimens and hospital discharge letters were kept with the relevant person's profile sheet. A sample of assembled packs contained full dispensing audit trails. Descriptions of medicines inside the packs were provided, this meant that people could identify medicines inside. The pharmacy supplied Patient information leaflets (PILs) with packs at the beginning of each four-week cycle.

The pharmacy sourced medicines from licensed wholesalers and specials manufacturers. Pharmacy team members were aware of FMD and a member of the team demonstrated how the pharmacy team were scanning and decommissioning FMD compliant medicines. The pharmacy had a system of highlighting assembled bags of medicines containing medicines which required decommissioning on hand-out. All staff had completed learning associated with FMD. A member of the team demonstrated how split packs of medicines were physically marked to indicate they had been decommissioned. This practice was put in place following staff feedback.

The pharmacy stored pharmacy (P) medicines in Perspex units close to the medicine counter. This appropriately protected them from self-selection. It stored medicines in the dispensary in an orderly manner and generally within their original packaging. An amber bottle with a hand-written label stating it was Gaviscon Advance was found during random checks of dispensary stock. The bottle contained no batch number or expiry date of the medicine inside. The RP confirmed that she would address the missing information from the label as a learning point with the team. A member of the team demonstrated batch labels which were available if needing to store medicines out of their original packaging. Pharmacy team members recorded date checking tasks on a regular basis. A random check of dispensary stock found no out of date medicines. A system was in place for highlighting short-dated medicines. The team annotated details of opening dates on bottles of liquid medicines.

The pharmacy held CDs in secure cabinets. Medicines storage inside the cabinets was orderly. There was a designated area for storing patient returns, and out-of-date CDs within a cabinet. The pharmacy's fridge was clean, and it was a sufficient size for the cold chain medicines held. A thermometer and data

logger were in place. Temperature records confirmed that it was operating between two and eight degrees. There was evidence of further checks being carried out if the temperature fell outside of this range. For example, when the door had been left open during cleaning and date checking. The pharmacy held assembled cold chain medicines in clear bags. This prompted additional checks of the medicines inside prior to hand-out.

Medical waste bins and CD denaturing kits were in place to assist the team in disposing of pharmaceutical waste and returned medicines.

The pharmacy received drug alerts by email. Pharmacy team members explained how they checked stock, recorded any action taken on the alert and retained a copy for reference purposes. There were no outstanding alerts waiting for action at the time of inspection.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide its services safely. And its team members regular check equipment to ensure it remains safe to use and fit for purpose. Pharmacy team members protect people's privacy when using the pharmacy's equipment and facilities.

Inspector's evidence

Pharmacy team members had access to up to date written reference resources. These included the British National Formulary (BNF) and BNF for Children. Internet access and intranet access provided further reference resources.

Computers were password protected and faced into the dispensary. This prevented unauthorised access to the contents on screen. Pharmacy team members had personal NHS smart cards. The pharmacy stored assembled bags of medicines waiting for collection and delivery on shelving to the side of the dispensary. The pharmacist's checking station included a counselling bench. Pharmacists worked vigilantly in this area and moved documents containing people's private information before calling a person up to the bench to hand-out a medicine and provide counselling. The pharmacy had cordless telephone handsets in place. Pharmacy team members moved to the back of the dispensary, out of ear shot of the public, when speaking with people on the phone. This meant that the privacy of the caller was protected.

Clean, crown stamped measuring cylinders were in place. Cylinders for use with methadone were stored separately The MethaMeasure machine was calibrated against 3 doses each day and the pharmacy kept a record of these checks. The pharmacy had a service contract for the machine which provided either remote or on-site engineer support if required. Counting equipment for tablets and capsules was available. This included a separate triangle for use with cytotoxic medicines. Equipment used for dispensing medicines into multi-compartmental compliance packs was single use. Gloves were available if needed. Up to date equipment was provided for the NHS health check service. Equipment was relatively new and as such had not yet been subject to calibration checks. It was procured through a reputable supplier. Stickers on electrical equipment showed that visual safety checks were carried out in October 2018.

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.