General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: J England Pharmacy Ltd, 280 Gidlow Lane, WIGAN, Lancashire, WN6 7PG

Pharmacy reference: 1075713

Type of pharmacy: Community

Date of inspection: 30/09/2024

Pharmacy context

This community pharmacy is situated next to a medical centre. It is located in a residential area of Wigan, Greater Manchester. The pharmacy dispenses NHS prescriptions, private prescriptions and sells over-the-counter medicines. It also provides a range of services including the NHS Pharmacy First service. The pharmacy supplies medicines in multi-compartment compliance packs to some people to help them take their medicines at the right time. The pharmacy recently changed ownership in the past 12-months.

Overall inspection outcome

✔ **Standards met**

Required Action: None

Follow this link to find out what the inspections possible outcomes mean

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 team follows written procedures, and this helps them to provide services safely and effectively. The pharmacy keeps the required records. And members of the team show an understanding of how to keep people's information safe. Members of the team record and discuss when things go wrong. But they do not always assess the risks when implementing new systems to ensure all of the risks have been considered and suitably managed.

Inspector's evidence

The pharmacy had written standard operating procedures (SOPs). There was a space to insert details of when they had been issued, who had authorised its use, and when they were due for review. But these details had not been completed, which would be useful information in the event of a query and to ensure they were routinely kept up to date. The SOPs had recently been implemented in March 2024, and members of the pharmacy team had signed training sheets to say they had read and accepted the SOPs.

A new system had been implemented by the pharmacy which involved the use of artificial intelligence to clinically screen prescriptions by the patient medical record (PMR) software. The pharmacist activated the functionality within the system, and it operated for a four-hour time period. During this time the PMR system used artificial intelligence to assess whether pharmacist intervention was required. If the PMR assessed the prescription to be clinically appropriate, it did not require further intervention by the pharmacist. The prescriptions which required intervention were flagged, including any prescriptions which contained medicines with a major interaction. Flagged prescriptions could not be dispensed until they have been reviewed as part of an audit, and the system could not be reactivated until the audit process had been completed. The audit process involved the pharmacist reviewing each flagged prescription, and indicating whether it needed intervention, or if it could continue without pharmacist intervention. But the pharmacist was not fully aware about how the system arrived at its decision to highlight prescriptions or not, and a risk assessment had not been completed before the system was implemented. So the pharmacy was not able to demonstrate they had considered all the risks associated with the use of this software.

The pharmacy had a process to identify and manage risk, such as the recording of dispensing errors and details of the learning outcomes. A paper log was used to record near miss incidents. The pharmacist discussed near miss incidents with members of the team at the time they occurred to help identify potential learning points. At the end of each month, the pharmacist analysed the records to look for common trends and potential learning points to help reduce similar mistakes. Details of the learning points were shared with members of the team. To help prevent common picking errors, the team had placed alert stickers for the similar sounding medicines amlodipine and amitriptyline.

The roles and responsibilities for members of the team were documented within SOPs. A dispenser explained what their responsibilities were and was clear about the tasks that could or could not be conducted during the absence of a responsible pharmacist. Members of the pharmacy team wore standard uniforms. The correct responsible pharmacist (RP) notice was on display. The pharmacy had a complaints procedure. Any complaints were recorded and followed up by the pharmacist manager. A current certificate of professional indemnity insurance was available.

Records for the RP, private prescriptions and unlicensed specials appeared to be in order. Controlled drugs (CDs) registers were suitably kept. Running balances were recorded and frequently checked. Three random balances were checked and were found to be accurate. Patient returned CDs were recorded.

An information governance policy was available in a folder. Members of the team had signed confidentiality agreements as part of their contracts. But they had not signed training sheets related to the IG policies. So the pharmacy may not be able to show team members fully understood their responsibilities to protect people's information. However, when questioned, a dispenser described how confidential information was separated and then subsequently removed and destroyed by a waste carrier. A notice in the retail area provided information about how the pharmacy handled and stored people's information. Safeguarding procedures were available in a folder, and these contained the contact details for local safeguarding teams. The pharmacist had completed level 2 safeguarding training. Members of the team explained they would refer any concerns to the pharmacist in the first instance.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough team members to manage the workload safely. And they complete the necessary training, or undertake training, for their role. But ongoing learning is not routinely provided, so learning needs may not always be identified or addressed.

Inspector's evidence

The pharmacy team included a pharmacist manager, a pharmacy technician, nine dispensers, four medicine counter assistants, three of whom were in training, and two delivery drivers. All members of the pharmacy team were appropriately trained or on accredited training programmes. The volume of work appeared to be well managed. Staffing levels were maintained by a staggered holiday system and part-time team members. A second pharmacist worked one day each week.

Members of the pharmacy team had completed some additional training. For example, they had previously completed training about antibiotic stewardship. But ongoing training was not provided in a consistent manner, which would help to ensure learning needs were met. A dispenser provided examples of selling a pharmacy only medicine using the WWHAM questioning technique, refusing sales which they felt were not appropriate, and referring people to the pharmacist when needed.

Members of the team felt well supported by each other. They were seen working well together and assisted each other with any queries they had. They discussed their work each day and shared any learning points. Appraisals had not yet been provided but had been scheduled in by the pharmacist manager. Team members were aware of the whistleblowing policy and said that they would be comfortable reporting any concerns to the superintendent pharmacist. There were no targets for professional based services.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are suitable for the services provided. A consultation room is available for people to have a private conversation with a member of the team.

Inspector's evidence

The premises was clean and tidy, and appeared to be adequately maintained. People in the retail area were not able to view any patient sensitive information due to the position of the dispensary. The temperature was controlled using air conditioning units and lighting was sufficient. Team members had access to a kitchenette area and WC facilities.

A consultation room was available. It was tidy with a computer, desk, seating, wash basin, and adequate lighting. The patient entrance to the consultation room was clearly signposted.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's services are easy to access. And it manages and provides them safely. It gets its medicines from licensed sources, stores them appropriately and carries out regular checks to help make sure that they are in good condition. But members of the pharmacy team do not always know when they are handing out higher-risk medicines. So they might not always be able to check that the medicines are still suitable, or give people advice about taking them.

Inspector's evidence

The pharmacy and consultation room were easily accessible by those with additional mobility needs. Information was on display about the services offered. The pharmacy opening hours were also on display.

The pharmacy used a PMR system which had built-in accuracy checking software. Prescriptions were organised into different 'workflows' on the PMR system and assigned to different roles within the pharmacy team. The first workflow was for a clinical check to be completed of each prescription. The pharmacist would either carry out the clinical check themselves or activate the PMR's automated clinical checking software. The prescription was then released to the dispensing team, who would pick the stock and scan each box of medication using the PMR system. If the medication matched the prescription, a dispensing label would print, and the dispenser would affix this to the box. If it did not match the dispenser had to amend the product or request assistance from the pharmacist. The pharmacist did not perform a further accuracy check unless the medicine fell within an exception category. For example, a CD or a split pack. The PMR system kept an audit trail of who carried out each stage of the process.

Dispensed medicines awaiting collection were kept on collection shelves. Barcode scanners were used to record the location of the bags. Prescription forms were retained, and stickers were used to clearly identify when fridge or CD safe storage items needed to be added. Members of the team were seen confirming the patient's name and address when medicines were handed out. The barcode scanner highlighted any prescriptions which had expired and could no longer be supplied, such as 28-day prescriptions for schedule 3 or 4 CDs. The barcode scanners also highlighted any additional notes or counselling advice the pharmacist would like the team to provide. But the team did not routinely highlight prescriptions containing higher-risk medicines (such as warfarin, lithium, and methotrexate) to remind the team to provide counselling advice and help ensure people continued to take their medicines safely. Members of the team were aware of the risks associated with the use of valproate and topiramate-containing medicines, and the need to supply full packs. Educational material and counselling advice was provided with these medicines. But details of the counselling advice were not recorded, which would help with the continuity of patient care.

Some medicines were dispensed into multi-compartment compliance packs. Before a person was started on a compliance pack the team completed a suitability assessment. A record sheet was kept for each patient, containing details about their current medication. Any medication changes were confirmed with the GP surgery before the record sheet was updated. Hospital discharge information was sought and kept for future reference. The compliance packs were supplied with patient information leaflets (PILs). But medication descriptions were not routinely provided to help people to identify their

medicines. The team acknowledged they would provide these details going forward.

The pharmacy had a delivery service, and delivery records were kept. Unsuccessful deliveries were returned to the pharmacy and a card posted through the letterbox indicating the pharmacy had attempted a delivery.

Medicines were obtained from licensed wholesalers, and any unlicensed medicines were sourced from a specials manufacturer. A date checking record was available. The expiry dates of medicines were checked once every three months. Short-dated stock was highlighted using a sticker and the details were written into a diary. But some open liquid medication did not have the date of opening written onto the bottle so team members may not be able to confirm they remained suitable for use. The pharmacist admitted this was an oversight and removed any affected bottles. Controlled drugs were stored in the CD cabinets, with clear separation between current stock, patient returns and out of date stock. There were two medicines fridge, both equipped with a built-in thermometer. The minimum and maximum temperatures were being recorded each day and had been within the required range for the past three months. Patient returned medication was disposed of in designated bins located away from the dispensary. Drug alerts were received by email from the MHRA. These were printed, with the details of who actioned the alert, the action taken and when written onto the alert before being stored in a folder.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

Members of the pharmacy team have access to the equipment they need for the services they provide. And they keep the equipment clean in a manner expected of a healthcare setting.

Inspector's evidence

Team members accessed the internet for general information. This included the British National Formulary (BNF), BNFc and Drug Tariff resources. All electrical equipment appeared to be in working order. There was a selection of liquid measures with British Standard and Crown marks. Separate measures were used for methadone to prevent cross contamination. The pharmacy also had counting triangles for counting loose tablets including a designated tablet counting triangle for cytotoxic medication. Equipment was kept clean.

Computers were password protected and screens were positioned so that they weren't visible from the public areas of the pharmacy. A cordless phone was available in the pharmacy which allowed team members to move to a private area if the phone call warranted privacy. The consultation room was used appropriately. People were offered its use when requesting advice or when counselling was required.

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.