General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Well, The Pharmacy, Sheep Market Surgery, Ryhall Road, STAMFORD, Lincolnshire, PE9 1YA

Pharmacy reference: 1084087

Type of pharmacy: Community

Date of inspection: 04/10/2023

Pharmacy context

This pharmacy is next to a small hospital and dispensing GP surgery in Stamford, Lincolnshire. Its main services include dispensing NHS and private prescriptions and selling over-the-counter medicines. It provides the seasonal flu vaccination service, substance misuse services and some advanced NHS services. The pharmacy supplies some medicines in multi-compartment compliance packs, designed to help people remember to take their medicines. And it offers a medicine delivery service to people's homes.

Overall inspection outcome

Standards not all met

Required Action: Improvement Action Plan

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 not all met	2.1	Standard not met	Pharmacy team members are working under pressure and are not able to manage the workload. The situation is heightened due to lack of contingency plans to cover team members absence.
3. Premises	Standards not all met	3.1	Standard not met	The pharmacy is disorganised. The placement of baskets and boxes within the dispensary make some areas difficult to access. And they increase the risk of an adverse event occurring.
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's team members are struggling to manage the pharmacy's workload. But otherwise, the pharmacy generally identifies and manages risks to patient safety. It mostly keeps the records it needs to by law up to date. And it advertises how people can provide feedback about its services. The pharmacy protects people's confidential information appropriately. Its team members understand how to recognise and report safeguarding concerns to help protect vulnerable people. But due to staffing pressures they do not always have the time to engage in reporting and shared learning following mistakes made during the dispensing process.

Inspector's evidence

The pharmacy held a range of standard operating procedures (SOPs) electronically. These covered responsible pharmacist (RP) requirements, controlled drug (CD) management, dispensary processes and pharmacy services. Training records for permanent team members showed some minor gaps in the completion of learning associated with the SOPs. A team member with some outstanding learning confirmed they would be completing this as a priority. A locum member of the team on duty during the inspection confirmed that the company asked for assurance that they had read and understood SOPs prior to booking shifts at its pharmacies. Due to high staff-turnover and absence within the team there was some circumstances where team members were not following SOPs. For example, they were not regularly recording mistakes made and identified during the dispensing process, known as near misses.

Team members received verbal feedback following a near miss but explained they generally didn't have time to record these types of mistakes. The pharmacy did record mistakes that were made and identified following the supply of a medicine to a person, known as dispensing incidents. Actions taken to reduce risk following a mistake were not monitored and were seen to be short-lived. For example, the team had acted to separate pregabalin tablets and capsules within the dispensary drawers. But these were currently stored together as team members explained they had not been able to commit time to ensuring the change was fully implemented. There were no regular structured reviews of mistakes to help share learning and to reduce the risk of similar mistakes occurring.

The pharmacy had a complaints procedure, and this was advertised alongside a notice asking people visiting the pharmacy to respect its team members. Pharmacy team members aimed to resolve concerns locally in the first instance and provided people with the details of the pharmacy's head office if people wished to escalate a concern. A team member reflected on some of the pressures caused by people being verbally abusive to team members and how this affected team morale. Pharmacy team members completed mandatory safeguarding learning to help them protect vulnerable people. But a team member was not aware of how they should respond if somebody came into the pharmacy using code words associated with a request for the pharmacy to provide a safe space for people experiencing domestic abuse. The pharmacy's chaperone notice and privacy notice were displayed inside its consultation room.

The pharmacy stored personal identifiable information in staff-only areas of the premises. It held confidential waste securely and this was collected periodically by a secure shredding service. The team completed mandatory data protection learning. The pharmacy had current indemnity insurance. The RP notice displayed contained the correct details of the RP on duty. The RP record was generally

completed in full; occasional records did not have the sign-out times of the RP. A sample of records associated with private prescriptions were seen to be completed in accordance with requirements. But some certificates of conformity for the supply of unlicensed medicines did not contain details of who the medicine had been supplied to. The pharmacy held its CD register electronically. Records conformed to legal requirements. The pharmacy was not carrying out full balance checks of physical stock as often as its SOPs stated. But in recent months the frequency of full balance checks had increased. The RP on duty had completed a full balance check of stock against the register on Monday 2 October 2023. This had revealed several discrepancies which they were in the process of investigating. The RP was aware of the next steps for reporting any unresolved discrepancies. Balance checks of several solid dose formulation CDs completed during the inspection complied with the balances recorded in the CD register. The pharmacy held a record of patient returned CDs and team members entered these into the record at the time of receipt.

Principle 2 - Staffing **Standards not all met**

Summary findings

The pharmacy team is struggling to keep up with its workload due to staff turnover and absence. There are times when its contingency arrangements do not adequately cover team members leave. This heightens workload pressure and impacts on risk management. And it leaves little time for the team to carry out processes designed to share learning and reduce risk. Pharmacy team members engage in some conversations at work, and they feel able to provide feedback. They undertake appropriate learning relevant to their roles.

Inspector's evidence

The RP was a locum pharmacist who had been working regular shifts at the pharmacy. Also on duty was the pharmacy's team leader and three qualified dispensers. One of the qualified dispensers worked for the company's relief team and another was a locum dispenser employed through an agency. A team member explained that the pharmacy was actively recruiting to fill two vacancies. They reported that both staff turnover and absence levels were high. An accuracy checking pharmacy technician (ACPT) was on long term unplanned leave, a delivery driver and a new team member were also absent from work. The team leader was also an ACPT but due to staffing levels and skill mix was not able to regularly undertake accuracy checking tasks. Workload was behind schedule. A server malfunction several days before the inspection was partially to blame for this. But it was noted that some prescriptions dated as far back as 18 and 19 September 2023 were still being dispensed by the team. The team did work hard to send as many prescriptions as possible to its offsite dispensing hub pharmacy.

Team members acknowledged that it was an ongoing struggle to keep up to date with workload as they started to fall behind when staffing levels fell. They asked for support via a secure messaging application when staffing levels were low. But despite this they reported that only the pharmacist and one other team member was on duty several days in September, and on other occasions there was only a pharmacist and two team members. This increased workload pressure on the team members working significantly. The pharmacy had some targets associated with its services. It was not currently meeting some of these targets due to a focus on catching up with dispensing tasks and delivering the flu vaccination service.

Team members were observed working well together and communicated effectively with each other to resolve queries. In addition to a busy walk-in business the team dealt with a lot of telephone queries, and this added to its workload. Resident team members completed regular e-learning relevant to their roles. They generally completed this in their own time. The team did not hold any structured meetings to support team members in sharing information following adverse events. Feedback was provided in informal one-to-one discussions between the team leader and team member. This meant there may be some missed opportunities to share learning and to ensure any actions taken were effective in preventing similar adverse events. The pharmacy had a whistleblowing policy and provided its team members with access to an employee assistance programme. Pharmacy team members were aware of how to raise concerns at work, and they knew how they could escalate concerns. They explained they would seek support from their area manager in the first instance.

Principle 3 - Premises **Standards not all met**

Summary findings

The pharmacy premises are disorganised. The placement of baskets on the dispensary floor represents a tripping hazard. And the untidy workbenches increase the risk a dispensing mistake being made. The premises are secure and people using the pharmacy can speak to a team member in a private consultation room.

Inspector's evidence

The pharmacy was secure and generally clean. But floors required cleaning where debris had built up, particularly within the dispensary. The public area was open plan and led to the medicine counter. To the side of this area was a private consultation room. The consultation room was tidy and accessible to members of the public. The dispensary was disorganised; overflowing delivery boxes from wholesalers held behind the medicine counter did not present a professional image to people visiting the pharmacy. A workbench at the back of the dispensary held baskets of prescriptions and medicines, these were stacked in an untidy manner with some baskets tipped at an angle which risked the contents spilling into others. Baskets with partially assembled prescriptions inside were also held on the floor towards the back of the dispensary. Boxes of stock held at the back of the dispensary also made it difficult to access fridges. And the items on the floor represented a tripping hazard for staff. There was clear work bench space available to support the pharmacist's accuracy checks of medicines, dispensing of acute prescriptions and protected space for managing the pharmacy's multi-compartment compliance pack service. Checks with team members confirmed the current working environment was not due to the one-off server incident. And it was clear that some of the baskets had been on the workbench for some time.

The pharmacy was air conditioned and lighting throughout the premises was bright. Pharmacy team members had access to toilet facilities and sinks equipped with antibacterial hand wash and paper towels. A separate sink in the front part of the dispensary provided space for reconstituting liquid medicines. But access to another sink towards the back of the dispensary was compromised due to clutter.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy is accessible to people. And its team members provide people with relevant information about their medicines to help them take them safely. The pharmacy obtains its medicines from reputable sources. And it stores its medicines securely. But the pharmacy team is struggling to keep up to date with key house keeping tasks designed to ensure medicines are stored orderly and are safe and fit to supply. This could increase the chance of a mistake occurring.

Inspector's evidence

People accessed the pharmacy through a manual door from the onsite carpark. The pharmacy displayed its opening times and details of the services it provided. It had chairs available against the window in its public area for people. Pharmacy team members knew how to signpost people to other pharmacies or healthcare services should they be unable to provide a service or supply a medicine. The pharmacy protected Pharmacy (P) medicines from self-selection by displaying these behind the medicine counter. The RP was able to supervise the activity taking place in the public area from the dispensary. A team member explained the vigilance they applied when managing requests for higher-risk P medicines that were subject to abuse, misuse, and overuse. They discussed how they referred repeat requests to a pharmacist and was aware of requests being refused and people being signposted to their GP on occasion.

Pharmacists provided verbal counselling associated with the ongoing monitoring of higher-risk medicines. The RP demonstrated the range of information resources available to support them with this counselling. For example, insulin passports. The team recorded some of these types of interventions to support continual care. The pharmacy had tools to support team members in complying with the valproate Pregnancy Prevention Programme (PPP). The team understood the requirements of the PPP and the RP discussed the additional counselling and checks required when supplying valproate to a person within the at-risk group.

Pharmacy team members used coloured baskets throughout the dispensing process. This process was designed to help keep medicines with the correct prescription form and support the smooth management of work. The team prioritised processing tasks associated with sending prescription information to the company's offsite dispensing hub pharmacy. The pharmacy's processes for this service ensured a pharmacist completed data accuracy and clinical checks of prescriptions prior to transmitting data to the hub pharmacy. Some prescriptions were part-dispensed locally and part-dispensed by the offsite dispensing hub pharmacy. The team used handheld devices with barcode technology to support it in ensuring all medicines on a prescription were supplied to people. These devices allowed team members to check the status of prescriptions and identify any medicines waiting to be dispensed locally. Pharmacy team members routinely signed the 'dispensed by' and 'checked by' boxes on medicine labels to form a dispensing audit trail. The pharmacy retained prescriptions for the medicines it owed to people. This supported team members in making appropriate checks when later supplying the medicines. The pharmacy did not always maintain an audit trail of the medicines it delivered to people's homes. The usual delivery driver kept an electronic audit trail of the medicines they delivered. But the pharmacy had recently been using a courier service. The RP showed the records of delivery they personally made to support the service. But there were some gaps in records when the

RP was not on duty. This meant the pharmacy did not always have an audit trail of the medicines it delivered to people's homes to support it in answering queries that arose.

The team managed tasks for the supply of medicines in multi-compartment compliance packs effectively. This workload was planned on a schedule and time was allocated to a team member to ensure workload remained up to date. A relief dispenser generally completed this workload. But other team members knew how to complete tasks and could support this service if needed. The pharmacy used individual profile sheets to record details of people's medicine regimens. But changes to medicine regimens were not generally recorded with information about the change. A sample of assembled compliance packs contained full dispensing audit trails and descriptions of the medicines inside them. But the backing sheets containing this information were not secured to the compliance packs. This meant they could easily become separated from the compliance pack once dispensed. The pharmacy routinely supplied patient information leaflets alongside compliance packs at the beginning of each four-week cycle.

The pharmacy sourced medicines from licensed wholesalers. Medicines were not always stored in an orderly manner within the dispensary. Random checks of stock medicines found different strengths of the same medicine stored together and in multiple locations within the same drawer. This could increase the chance of a picking error occurring. A team member explained they were struggling to stay up to date with keeping the stock organised. A sample of stock checked also found a handful of out-of-date medicines. Team members were aware that they were not up to date with date checking tasks and were seen to be checking expiry dates thoroughly throughout the dispensing process to reduce the risk of supplying an out-of-date medicine. The pharmacy stored medicines requiring safe custody in secure cabinets. Medicines inside the cabinets were stored in an orderly manner with separate areas for holding assembled medicines, out-of-date medicines, and patient-returned medicines. The pharmacy had three fridges to store medicines requiring cold storage. Fridge temperature records confirmed they were operating within the correct temperature range of two and eight degrees Celsius. But there were some gaps within the temperature record. The pharmacy had appropriate medicine waste receptacles and CD denaturing kits available. It received and actioned medicine alerts electronically through a task tracker system.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs to provide its services. And its team members act with care by using the equipment in a way which protects people's confidentiality.

Inspector's evidence

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

The pharmacy had a range of clean and suitable equipment to support its team members in counting and measuring medicines. For example, crown stamped glass measures to accurately measure liquid medicines. Specific measures were highlighted for use with higher-risk medicines to mitigate the risk of cross-contamination. Equipment used to support the delivery of pharmacy services was from reputable manufacturers. Equipment used to deliver the flu vaccination service included quick access to medicines used to treat an anaphylactic reaction. The pharmacy's electrical equipment had last been subject to portable appliance testing in 2022.

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.