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: 15/04/2024

Pharmacy context

This pharmacy is next to a small hospital and dispensing GP surgery in Stamford, Lincolnshire. Its main services include dispensing prescriptions and selling over-the-counter medicines. It provides a range of NHS advanced services including the New Medicine Service, Contraception Service, Hypertension Case-Finding Service, and the NHS England Pharmacy First Service. 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 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 effectively identifies and manages the risks for providing its services. It mostly keeps the records required by law and it manages people's confidential information with care. Its team members are confident in responding to feedback from people using the pharmacy. And they know how to recognise and report safeguarding concern to help keep vulnerable people safe from harm. Pharmacy team members engage in regular conversations to share learning following the mistakes they make during the dispensing process. And they act to reduce risk following these discussions.

Inspector's evidence

The pharmacy held a range of standard operating procedures (SOPs) to support its safe and effective running. Its team members accessed these via their personal learning accounts. The responsible pharmacist (RP) on duty was the pharmacy manager. They received regular performance updates from their area operation manager. The updates supported the manager in planning time and support for team members with outstanding learning related to the SOPs. The current training update identified some outstanding learning for newer members of the team. Team members demonstrated a good understanding of their roles and responsibilities. And they were observed following SOPs when completing tasks during the inspection.

The pharmacy had processes for reporting and learning from mistakes made and identified during the dispensing process, known as near misses. Team members received verbal feedback following a near miss and they made efforts to report their mistakes on a digital reporting tool. The team also recorded mistakes it identified following the supply of a medicine to a person, known as a dispensing incident. The RP analysed mistake records each month and shared learning from these events with team members through structured patient safety reviews. The patient safety reviews focussed on actions taken to reduce risk and identified areas for improvement. A recent review had shared learning about the reclassification of a medicine, and it highlighted the need for team members to ensure the timely completion of some stock management tasks. The team also engaged in wider learning during these reviews by discussing 'share and learn' case studies shared with the pharmacy by its superintendent pharmacist's team. The RP encouraged team members to acknowledge their engagement in the patient review process by asking them to read and sign records of the review.

The pharmacy had a complaints procedure, and it clearly advertised this through a notice at the medicine counter. Pharmacy team members knew how to respond to feedback and how to escalate a concern if needed. They aimed to resolve concerns locally in the first instance. The pharmacy displayed details of its chaperone policy to people. Pharmacy team members engaged in mandatory safeguarding learning. They had access to information to support them in raising safeguarding concerns, including details of local safeguarding agencies. A team member discussed how they would recognise and seek support in reporting a concern. But not all team members were aware of code words commonly promoted by domestic violence safety charities to support people in accessing a safe space. Team members completed mandatory data protection learning. The pharmacy displayed its privacy notice. This provided people with information about how it used their personal information. It stored personal identifiable information in staff-only areas of the premises. And it disposed of its confidential waste securely.

The pharmacy had current indemnity insurance. The RP notice displayed the correct details of the RP on duty. The RP record was generally completed as required. But there were some records made by a locum pharmacist on Saturdays that were inaccurate as the pharmacist had not completed the record at the time of assuming the RP role. The pharmacy completed its private prescription records in accordance with legal requirements. It did not keep all certificates of conformity for the supply of unlicensed medicines in an orderly manner. This meant it may be more difficult for team members to respond to a query about an unlicensed medicine if one arose. The pharmacy held its controlled drug (CD) register electronically and it maintained running balances in the register. The team completed full physical balance checks of its CDs against the running balances in the register frequently. The RP had acted to report two recent unresolved discrepancies in line with the pharmacy's SOPs. And they discussed learning and risk reduction actions following one these discrepancies to help reduce the risk of a similar mistake occurring. Random physical balance checks completed during the inspection complied with the running balances within 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 met

Summary findings

The pharmacy employs a team with the appropriate skills and knowledge to deliver its services. Pharmacy team members engage in regular conversations to help manage workload and minimise risk. They receive regular support to keep their skills up to date. And they understand how to provide feedback should they have a concern at work.

Inspector's evidence

The RP had been employed as the pharmacy manager for around six months. They were working alongside two qualified dispensers. One dispenser was a member of the company's area relief team, they worked at the pharmacy regularly. The pharmacy also employed an accuracy checking pharmacy technician (ACPT), another qualified dispenser and a trainee dispenser. Its medicine delivery service was provided by a company employed driver. There had been some changes to the staffing structure and working hours of team members since the last inspection of the pharmacy six months ago. And these changes were ongoing with regular support from the area relief team to help cover gaps in the current rota. The pharmacy was in the process of recruiting additional staff. The RP explained this would either be one full-time team member or two part-time team members. The team had also reviewed how it managed workload. And it had made some changes to ensure team members received support with keeping their skills up to date. For example, the team had organised workload to ensure the ACPT was able to complete the accuracy check of some medicines. And there was a process to support pharmacists in undertaking the clinical check of prescriptions prior to the ACPT completing the accuracy check of a medicine. Team members were up to date with their work, and they were observed prioritising acute prescriptions to make sure people received their medicines in a timely manner.

The trainee dispenser was enrolled on a GPhC accredited training course associated with their role. And the manager monitored their progress with this learning. All team members engaged in mandatory learning to support them in their roles. This had included recent learning to support the launch of the NHSE Pharmacy First service. The pharmacy had a whistleblowing policy and it displayed information to support team members in raising a concern at work in confidence. Team members were confident in providing feedback and fed back to the pharmacy manager in the first instance. They understood how to escalate a concern if needed. Team members were observed supporting each other and working well together. They engaged in regular discussions to share information such as updates to services, workload management and the structured patient safety reviews. The RP had a positive attitude when discussing the pharmacy's targets for its services. And they felt able to apply their professional judgement when delivering pharmacy services.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are clean, secure, and appropriately maintained. People visiting the pharmacy can speak to a member of the team in a private consultation room.

Inspector's evidence

The pharmacy was secure and adequately clean. Team members knew how to report maintenance concerns and there were no current maintenance concerns noted. The pharmacy had air conditioning to help maintain an ambient temperature. 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 dispensary provided space for reconstituting liquid medicines.

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 fully accessible to members of the public and it offered a suitable space for providing private consultation services. A gate at the medicine counter deterred unauthorised access into the staff-only area of the premises. Some boxes held behind the medicine counter contained retail stock waiting to be unpacked. These distracted from the otherwise professional image of the pharmacy. The team used workspace effectively within the dispensary. It had designated areas for different activities. And it completed higher-risk tasks in the back area of the dispensary. This reduced the risk of distraction when completing these tasks. The RP had a designated checking bench which they kept clean and clutter free.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides its services safely and it makes its services readily available to people. The pharmacy obtains its medicines from reputable sources. Overall, it stores its medicines safely and securely. And its team members make appropriate checks to ensure medicines are safe to supply to people. Pharmacy team members take regular opportunities to speak to people about their health. And they provide supportive information when dispensing medicines to help people take their medicines safely.

Inspector's evidence

People accessed the pharmacy from street level and onsite parking was available. The pharmacy displayed its opening times and details of the services it provided. It had chairs available in its public area for people waiting for their medicine or for a service. Pharmacy team members knew to signpost people to other pharmacies or healthcare providers 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 activity at the medicine counter from the dispensary. They were observed counselling people when handing out medicines. And they had a range of information to support them in counselling people taking higher-risk medicines. The team recorded some of these interventions to support it in providing continual care. The pharmacy had tools to support team members in complying with the valproate Pregnancy Prevention Programme (PPP). And team members were aware of the most recent legal changes requiring the supply of valproate in the manufacturers original packaging. The RP discussed the checks required when supplying valproate to a person within the at-risk group. The pharmacy promoted its services well to people. Team members identified people eligible for services during the dispensing process. And it effectively highlighted bags of assembled medicines to prompt conversations with people about these services. Pharmacists had access to supportive information to help them deliver consultation services safely and effectively. This information included current patient group directions and service specifications. The NHS England clinical pathways for the Pharmacy First service were available to refer to within the consultation room.

Pharmacy team members used coloured baskets throughout the dispensing process. This process kept medicines with the correct prescription form and identified those for priority dispensing. The team sent some of its workload 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 barcode technology which tracked the dispensing process. This supported it in identifying where a prescription was and in locating bags of assembled medicines to handout to people. Pharmacy team members generally signed the ‘dispensed by’ and ‘checked by’ boxes on medicine labels to form a dispensing audit trail. One example of a multi-compartment compliance pack did not identify who had assembled the pack. The pharmacy retained prescriptions for the medicines it owed to people. And team members made regular checks of medicine availability to help ensure they supplied these medicines before people ran out. They also notified local prescribers of long-term supply issues to help inform prescribing decisions. The pharmacy kept an

electronic audit trail of the medicines it sent through its delivery service. This supported team members in answering any queries that arose about the service.

The team managed tasks for the supply of medicines in multi-compartment compliance packs effectively. It planned its workload for this service using workload tracker. And it completed the assembly of compliance packs in a quiet area of the dispensary which effectively reduced the risk of distraction during the dispensing process. The pharmacy used individual profile sheets to record details of people's medicine regimens. And it used event diaries within these records to record details of changes to people's medicine regimens. A sample of assembled compliance packs contained descriptions of the medicines inside them. But the pharmacy did not physically attach the backing sheets containing this information to the compliance packs. This meant the information may 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. It generally stored medicines in an orderly manner. And team members made efforts to organise medicines when conducting routine expiry date checks of its medicines. The team recorded these checks on a digital date checking matrix. A random sample of stock checked also found no out-of-date medicines. Team members annotated bottles of liquid medicines with the date they opened them. This supported them in making checks to ensure the medicine remained safe to supply to people. The pharmacy kept its CDs securely. But it was storing one CD in a secure cabinet that did not comply with safe custody regulation. The RP relocated this to a compliant cabinet during the inspection. It held stock inside its CD cabinets in an orderly manner with designated space for holding 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. The pharmacy had appropriate medicine waste receptacles and CD denaturing kits available. It received and actioned medicine alerts electronically through a task tracker system. A bottle of a liquid medicine which had been removed from the UK supply chain in 2023 was found amongst stock held in the dispensary. The RP acted immediately to quarantine this medicine ready for safe disposal. The team discussed information about alerts within its monthly patient safety reviews.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has suitable equipment readily available for use. Its team members use the equipment in a way which protects people's confidentiality.

Inspector's evidence

Pharmacy team members had access to the company's intranet, the internet and current reference resources to support them in obtaining information. The layout of the premises protected information on computer monitors from unauthorised view. And team members used individual NHS smart cards and passwords when accessing people's medication records. 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 standardised equipment to support its team members in counting and measuring medicines. And it had separate equipment for counting and measuring higher-risk medicines to mitigate any risk of cross-contamination. It stored the equipment for its consultation services within the consultation room. This equipment was from recognised manufacturers and available for use. 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.