General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Well, Ashby Turn Medical Centre, The Link, Ashby High Street, SCUNTHORPE, South Humberside, DN16 2UT

Pharmacy reference: 1084420

Type of pharmacy: Community

Date of inspection: 19/08/2024

Pharmacy context

This pharmacy is within the grounds of a medical centre in Ashby, a suburb of Scunthorpe in North Lincolnshire. Its main services include dispensing prescriptions and selling over-the-counter medicines. It provides a range of NHS consultation services including Pharmacy First, the New Medicine Service (NMS), contraception and blood pressure checks. 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

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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 effectively identifies and manages the risks for the services it provides. It keeps its records as required by law and it manages confidential information securely. Pharmacy team members know how to manage feedback and concerns from people using the pharmacy's services. They act to raise concerns to help keep vulnerable people safe from harm. And they engage in regular conversations to help share learning and reduce risk following the mistakes they make during the dispensing process.

Inspector's evidence

The pharmacy held a range of standard operating procedures (SOPs) to support its safe and effective running. Its superintendent pharmacist's team reviewed the SOPs on a rolling two-year cycle. And it introduced new SOPs prior to implementing new services. Pharmacy team members accessed them via their personal learning accounts. They completed competency assessments to help ensure they had understood them. The responsible pharmacist (RP) on duty was the pharmacy manager, they received regular training reports from the pharmacy's area manager to ensure all team members were up to date with their learning. Team members demonstrated a good understanding of the SOPs when completing tasks. A team member discussed the tasks that could not take place if the RP took absence from the premises. The pharmacy employed a pharmacy technician in an accuracy checking role (ACPT). The RP recorded clinical checks of prescriptions prior to the ACPT completing the final accuracy check of a medicine.

The pharmacy had processes for reporting and learning from mistakes made and identified during the dispensing process, known as near misses. The RP had reported these mistakes until recently. A new process encouraged team members to report their own near misses following feedback from accuracy checkers and correction of their mistake. The change was to help support consistent near miss reporting. The pharmacy had introduced it following monthly patient safety reports identifying that near misses were less likely to be reported if the manager was not on duty. The team provided examples of how they acted to reduce risk when trends in near misses were identified. For example, separating different strengths of the same medicine on the dispensary shelves to help reduce the risk of a picking error occurring. The pharmacy team recorded the mistakes it identified following the supply of a medicine to a person, known as a dispensing incident. A recent incident had involved a mistake made by the company's offsite dispensing hub pharmacy. The RP discussed the steps they took to resolve the mistake. And the pharmacy's reporting procedures supported it in identifying the source of the mistake. The pharmacy shared details of the mistake with the dispensing hub pharmacy to support it in investigating and learning from its own mistakes.

The pharmacy had a complaints procedure, and it advertised this on a notice near the medicine counter. A team member explained how they would respond to concerns and how they would provide details of the pharmacy's head office if the team could not resolve a concern locally. Pharmacy team members had completed safeguarding training to support them in identifying and reporting safeguarding concerns. Team members had access to contact information to support them in reporting a concern and they regularly shared information with people's own GP's when they identified concerns involving a person's health or when a person required additional support to help them take their

medicines safely. A team member explained how they would support a person requesting use of a safe space.

The pharmacy displayed a notice explaining to people how it processed their personal information. It stored personal identifiable information in staff-only areas of the premises. And it disposed of its confidential waste securely. Team members engaged in mandatory information governance training to support them in maintaining people's confidentiality. The pharmacy had current professional indemnity insurance. The RP notice displayed the correct details of the RP on duty. A sample of the RP record and private prescription register checked were completed as required. The pharmacy held its controlled drug (CD) register electronically. Records were made in accordance with legal requirements. The team completed full physical balance checks of its CDs against the running balances in the register frequently. Random physical balance checks completed during the inspection matched the running balances within the CD register. The pharmacy held a record of patient returned CDs and this was completed to date.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy employs people with the skills and knowledge to deliver its services. Its team members complete regular learning relevant to their roles. And they engage in ongoing conversations to support them in working safely. Pharmacy team members understand how to provide feedback about the pharmacy, and how to raise a concern at work.

Inspector's evidence

The RP was working alongside two dispensers and a pharmacy technician. The pharmacy also employed the ACPT, and two other dispensers. It had a current part-time vacancy. Team members worked flexibly to cover the opening times with over-time available to support team members in covering each other's leave. The pharmacy was one of two in the town, owned by the same company. The RP explained that occasionally the two pharmacy teams would support each other to help manage unplanned leave. A company employed delivery driver provided the medicine delivery service. The team was up to date with its work. It used a rota which saw all team members regularly complete a variety of tasks, such as covering the medicine counter, dispensing urgent prescriptions, and assembling medicines in compliance packs. This helped to ensure team members were competent in the areas they worked and supported the team in managing workload should an unplanned absence occur.

All team members had completed formal training to support them working safely in their roles. They engaged in some ongoing learning at work. And they were supported by a structured appraisal process and conversations at work to help them develop and improve in their roles. The pharmacy's ACPT completed regular self-reflection reviews of their checking skills. The team used short briefings to share information such as learnings from patient safety reviews and email updates sent by the pharmacy's head office or area manager. A team member explained that informal conversations at work helped to highlight and reduce risk. For example, by bringing team members attention to medicines in similar packaging when unpacking stock orders.

The pharmacy had a whistleblowing policy and it displayed information to support team members in raising a concern at work in confidence. Team members understood how to raise and escalate a concern at work. The RP had provided feedback about staff safety at work and the company had responded by reviewing and making changes to the pharmacy's security arrangements. The pharmacy had some targets for the services it provided. The RP discussed these targets and demonstrated how the company monitored performance. They felt able to apply their professional judgement when delivering pharmacy services and discussed their approach to delivering services.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is secure and adequately maintained. Overall, it provides a professional environment for delivering healthcare services. People visiting the pharmacy can speak to team members in confidence in a private consultation room.

Inspector's evidence

The pharmacy was secure and maintained to an appropriate standard. There was a process for reporting maintenance concerns and the RP was observed following this to report a faulty light tube in the staff kitchen during the inspection. The pharmacy was generally clean, but the floor was heavily marked in some areas, including in the public area where there was residue from stickers on the floor. Floor spaces were free from obstructions and trip hazards and workbenches throughout the dispensary were clear of clutter. Lighting was bright and air conditioning effectively controlled the temperature within the dispensary and public area. Pharmacy team members had access to sinks equipped with handwashing supplies and hand sanitiser was available for use. They used the dispensary sink to prepare liquid medicines.

The public area was relatively open plan and led to the medicine counter. The pharmacy's consultation room was accessible to the side of the public area. The room was a good size and was professional in appearance. The RP was observed using the room with people when providing consultation services. Workflow in the dispensary was efficient with labelling and assembly tasks completed on a workbench at the back of the dispensary and accuracy checking tasks completed on a work bench in front of this. There was appropriate shelving for holding baskets of assembled medicines waiting to be accuracy checked. A workbench at the side of the dispensary offered protected space for the completion of tasks for the multi-compartment compliance pack service. A door off the back of the dispensary led to staff kitchen and toilet facilities.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's services are accessible for people, and it delivers its services safely and effectively. It obtains it medicines from reputable sources, and it stores them appropriately. Its team members make regular checks to ensure medicines are safe to supply to people. And they provide relevant information and advice to people to support them in taking their medicines safely.

Inspector's evidence

People accessed the pharmacy from street level from the onsite carpark. The pharmacy displayed details of its opening times and services prominently in window displays. Pharmacy team members used their local knowledge to support them in signposting 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. And the RP was able to supervise activity in the public area from the dispensary. The RP demonstrated records of interventions they made when dispensing prescriptions and providing advice to people. The team used stickers on assembled bags of medicines to identify higher-risk medicines and medicines requiring additional monitoring. A notice for locum pharmacists at the pharmacist's checking station encouraged them to follow the pharmacy's processes in identifying these medicines. The team had a range of alert cards and monitoring booklets available to provide to people when dispensing these medicines. But it did not routinely take the opportunity to record these types of interventions to support it in providing continual care. Team members were aware of the requirements of medicines subject to Pregnancy Prevention Programmes (PPPs). And the RP provided details of the conversations they had with people when supplying these medicines to people in the at-risk group. The team understood the legal requirement to supply valproate in the manufacturer's original packaging. The RP discussed the risk assessment process they had followed when they identified a need to supply valproate outside of the manufacturer's original packaging. But they had not yet documented this risk assessment to support them in demonstrating how they were managing this risk.

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 RP took opportunities to meet with the local surgery team and to share information. For example, they had taken the opportunity to share information about the seven clinical conditions treated through the Pharmacy First service and the inclusion criteria for those conditions. The pharmacy identified new medicines during the dispensing process. It held assembled bags containing new medicines on a dedicated shelf within the dispensary. This prompted additional checks designed to ensure people collected the medicine in a timely manner. It also prompted the team to engage people in conversations about the New Medicine Service (NMS) to support them in taking their medicine safely. The RP had oversight of the NMS consultations required each day on the patient medication record (PMR) system. The RP discussed beneficial outcomes from people attending to have their blood pressure checked, this included people commencing treatment for previously undiagnosed high blood pressure requiring treatment.

Pharmacy team members used coloured baskets throughout the dispensing process. This process kept

medicines with the correct prescription form and identified workload priority. They signed the ‘dispensed by’ and ‘checked by’ boxes on medicine labels to form a dispensing audit trail. The pharmacy had clear audit trails of the medicines it delivered to people and of the medicines it owed to people. And team members regularly checked prescriptions for owed medicines to help ensure people were kept informed of any supply problems. This helped ensure people did not run out of their medicine. The team used a workload tracker to support it in managing the supply of medicines in multi-compartment compliance packs. It clearly recorded safety information within people's individual records, such as the checks it made when changes were made to people’s medication regimens. And it retained information to support these changes, such as hospital discharge letters. A sample of assembled compliance packs contained descriptions of the medicines inside them. And the pharmacy routinely supplied patient information leaflets alongside compliance packs at the beginning of each four-week cycle.

The team sent some of its workload to the company’s offsite dispensing hub pharmacy. The RP completed data accuracy and clinical checks of prescriptions prior to transmitting data to the hub pharmacy. A team member demonstrated how information on the PMR supported them in tracking the progress of a prescription sent to the dispensing hub pharmacy, including any items rejected. For example, if a medicine was unavailable at the dispensing hub pharmacy. The team followed a clear process when there was a need for it to dispense part of a prescription locally. It used barcode scanning to match assembled bags of medicines dispensed locally with those arriving from the hub pharmacy. This supported the team in ensuring people received all medicines on their prescription when people attended to collect them or when it sent them out for delivery. The RP or ACPT conducted daily checks to help monitor the safety of the hub pharmacy’s dispensing process. This saw them complete an independent accuracy check of medicines for one complete prescription and one part prescription arriving from the hub each day.

The pharmacy sourced medicines from licensed wholesalers. It stored medicines in their original packaging and in an orderly manner. The team documented the regular checks it completed to help ensure medicines were safe to supply. This included checking expiry dates of medicines held in stock and clearly highlighting medicines with short expiry dates. A random sample of stock held in the dispensary 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 in a cabinet and medicines inside were held in an orderly manner. The pharmacy had two medical fridges to store medicines requiring cold storage. Fridge temperature records confirmed they were mostly operating within the correct temperature range of two and eight degrees Celsius. Some minor fluctuations in temperature were recorded for both fridges recently. Team members explained this was due to stock checks and cleaning activity, but they had not recorded these checks within the record to help explain the fluctuations. The pharmacy had appropriate medicine waste receptacles and CD denaturing kits available. It received and actioned medicine alerts electronically through a task tracker system. And it kept an audit trail of the action it took in response to these alerts.

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 the equipment and facilities appropriately to protect people's confidential information.

Inspector's evidence

Pharmacy team members used password-protected computers and NHS smartcards when accessing people's medication records. The layout of the premises protected information on computer monitors from unauthorised view. And team members used a cordless telephone handset that allowed them to move to a quiet space when discussing confidential information over the telephone with people. The pharmacy stored bags of assembled medicines on shelves within the dispensary, shelves in view of the medicines counter were protected by frosted glass doors. This arrangement effectively protected people's personal information. The RP was observed referring to the British National Formulary (BNF) digital reference resource when completing clinical checks of prescriptions. And team members had access to the internet to support them in obtaining information.

The pharmacy had a range of clean and standardised equipment to support its team members in counting and measuring medicines. Team members used separate equipment for counting and measuring higher-risk medicines to mitigate any risk of cross-contamination. Equipment to support consultation services was readily available within the pharmacy's consultation room and the room was kept locked between use. The equipment was clean and checked regularly to ensure it remained safe to use. The pharmacy's electrical equipment had last been subject to portable appliance testing in November 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.