

Registered pharmacy inspection report

Pharmacy Name: Well, 40 Market Street, Whaley Bridge, High Peak,
STOCKPORT, SK23 7LP

Pharmacy reference: 1084623

Type of pharmacy: Community

Date of inspection: 11/03/2020

Pharmacy context

This busy community pharmacy is located in the centre of the village close to a medical centre. Most people who use the pharmacy are from the local area. The pharmacy dispenses mainly NHS prescriptions and it sells a range of over-the-counter medicines. It supplies a large number of medicines in multi-compartment compliance aid packs to help people take their medicines at the right time. Around 55% of prescriptions are sent to the company's hub to be dispensed.

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	The pharmacy team records and analyses adverse dispensing incidents to identify learning points which it incorporates into day to day practice to help manage future risks.
2. Staff	Good practice	2.2	Good practice	The team members have the appropriate skills, qualifications and competence for their role and the pharmacy supports them to address their ongoing learning and development needs.
		2.4	Good practice	The pharmacy team work well together. Team members communicate effectively, and openness, honesty and learning are encouraged.
3. Premises	Standards met	N/A	N/A	N/A
4. Services, including medicines management	Standards met	4.1	Good practice	People can access a wide range of services, and health and wellbeing are promoted to the community.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance ✓ Standards met

Summary findings

The pharmacy effectively manages risks to make sure its services are safe. It generally completes all the records that it needs to by law and it asks its customers for their views and feedback. Pharmacy team members work to professional standards and they are clear about their roles and responsibilities. They record their mistakes so that they can learn from them and they act to help stop the same sort of mistakes from happening again. Team members have a clear understanding of how to protect vulnerable people and they have written procedures on keeping people's private information safe.

Inspector's evidence

The pharmacy had up-to-date standard operating procedures (SOPs) for the services provided. Members of the pharmacy team confirmed electronically via an e-Learning system that they had read and accepted the procedures and they completed an assessment to test their understanding of each SOP. Roles and responsibilities were set out in SOPs and the pharmacy team members were performing duties which were in line with their role. Team members were wearing uniforms and name badges indicating their role. The incorrect name of the responsible pharmacist (RP) was on display at the start of the inspection, but this was corrected during the inspection. The pharmacy manager explained he was keen to get started on the back log of checking that morning, and he forgot to change the RP notice, from the previous day.

A business continuity plan was in place which gave guidance and emergency contact numbers to use in the case of systems failures and disruption to services. Additional resources had been obtained in light of the corona virus outbreak including stronger wipes for disinfecting solid surfaces. Public information notices about coronavirus were on display.

Dispensing incidents and near misses were reported on Datix intranet, which could be viewed at the pharmacy superintendent's (SI) office. Action taken at branch was completed to show the appropriate action had been taken at branch level to avoid re-occurrence. 'Share and learn' articles from the SI office were available on the intranet sharing learning within the organisation. The pharmacy manager explained that he read them and made all the team aware of the ones which he felt were most relevant to the pharmacy. For example, he had increased the team's focus on selecting the correct insulin as there has been incidents in other branches. He discussed the various types of insulin with the team at a patient safety huddle and highlighted the new types and strengths which were now available, to increase their awareness. Clear plastic bags were used for assembled insulin to allow an additional check at hand out and there was a 'Please check prescription' notice on the fridge, reminding team members to take the prescription with them to the fridge when selecting insulin. The pharmacy manager obtained an additional medical fridge to give the team more space to store the insulins, and the stock in the fridges was well organised to further reduce the risk of errors. 'Similar name check' stickers were in front of some look-alike and sound-alike drugs (LASAs) so extra care would be taken when selecting these. For example, Phenergan 25mg and promazine 25mg tablets. The pharmacy manager had one-to-one discussions with team members when a dispensing error occurred and completed monthly patient safety reviews, which were discussed with the pharmacy team.

There was a 'Customer Care' notice which gave the details of head office, in case of a complaint and

encouraged customers to give feedback, but it had been covered up by another notice. These details were also explained in the pharmacy's practice leaflets. The pharmacy manager uncovered the customer care notice and moved the practice leaflets to a more prominent place in the pharmacy. A customer satisfaction survey was carried out annually. The results of the most recent survey were available on www.NHS.uk website. Results indicated 99.4 % of respondents had rated the pharmacy very good or excellent. Areas of strength (100%) included the service received from the pharmacist, the service received from other staff, providing an efficient service, the staff overall and the cleanliness of the pharmacy. An area identified which required improvement was 'having somewhere available where you could speak without being overheard' (3.2% of respondents were dissatisfied). The pharmacy's published response was to 'Review consultation areas and consider if any changes can be made'. The pharmacy manager said he had requested two new consultation rooms within the main retail area as there was plenty of space, but this work had not yet been agreed. The current consultation room was not visible from the retail area. It was accessed through a door from the retail area into the back area, and there was a sign highlighting its availability on this door. There was also a notice in the pharmacy's window highlighting that a consultation room was available for private conversations and this was also included in the practice leaflet.

Professional indemnity insurance was in place. Private prescription, emergency supply and the RP records were all appropriately maintained. Some of the writing in the controlled drug (CD) register was untidy and some details were missing, such as the address where CDs were obtained from. And the invoice number was not usually recorded in the CD register, which might make it harder to resolve discrepancies. Records of CD running balances were kept and these were regularly audited. Two CD balances were checked and found to be correct. Patient returned CDs were recorded and disposed of appropriately.

All staff completed annual training on information governance (IG) which included confidentiality. Confidential waste was collected in designated 'shred-it' bins which were collected by a specialised disposal company. A dispenser correctly described the difference between confidential and general waste. Assembled prescriptions awaiting collection were stored appropriately so patients' details were not visible to members of the public. Paperwork containing patient confidential information was stored appropriately. An IG audit had been completed which identified that additional provisions for confidential waste disposal were required, so an additional shred-it bin had been obtained and collections of the bins were increased to monthly instead of every two months. A statement that the pharmacy complies with the Data Protection Act and the NHS Code of Confidentiality was given in the practice leaflet. A privacy statement was available in line with the General Data Protection Regulation (GDPR) and it was displayed on the consultation room door. The pharmacy sent people's prescriptions to the hub pharmacy in Stoke without obtaining explicit consent from the patient, which potentially breached patient confidentiality. Details of the hub pharmacy were on the bag label and medication label. But people were assumed to have 'opted in' unless they objected, when their record would be changed to 'opted out'. Similarly, the pharmacy sent people's prescriptions to a third party 'Wardles', a registered dispensing appliance contractor, for them to dispense, but consent was not requested for this which was a potential breach of their confidentiality. Consent was received when summary care records (SCR) were accessed.

The pharmacy manager, accuracy checking technician (ACT) and dispensers had all completed level 2 training on safeguarding. Other members of the team had completed safeguarding training relevant to their role on e-Expert learning. The delivery driver said she would voice any concerns to the pharmacist and described how on a recent occasion she had contacted the pharmacy because a person who was prescribed warfarin could not stop bleeding after being scratched by a cat. The pharmacy telephoned the person's GP, who arranged assistance. There was a safeguarding notice on display containing the

contact numbers of who to report concerns to in the area. The pharmacy had a chaperone policy and a notice was available highlighting this to patients. Members of the pharmacy team had completed Dementia Friends training, so had a better understanding of patients living with this condition, and some were wearing 'dementia friends' badges to highlight this.

Principle 2 - Staffing ✓ Good practice

Summary findings

The pharmacy's team members are well trained, and they work effectively together. The pharmacy encourages them to keep their skills up to date and supports their development. They are comfortable providing feedback to their manager and they receive feedback about their own performance.

Inspector's evidence

There was a pharmacy manager (RP), an ACT, five NVQ2 qualified dispensers (or equivalent), a trainee dispenser and a delivery driver on duty at the time of the inspection. The staffing level was adequate for the volume of work during the inspection. Staffing levels were planned using staff rotas and a separate late-night rota. Planned absences were organised on holiday rotas and cover could be requested from the relief team, which included qualified dispensers. There was also a relief team of pharmacists. The pharmacy manager had been working in another branch for the last couple of weeks so different relief pharmacists had been working as the RP. The pharmacy manager had come in early that day as he had been told there was a back log of checking of compliance packs for a care home. He said the ACT also came to work early when required and they had a dedicated team which worked extremely hard to keep on top of the workload. A review had been carried out of the staffing levels and another member of staff had been recruited as a result, and they were due to start working in the next few weeks.

Team members carrying out the pharmacy services had completed appropriate training and used the company's online training system e –Expert learning to keep their knowledge up-to-date. They were able to display their 'learning plan' which was a record of their completed training and included topics such as LASAs, sepsis, IG and data security. The pharmacy manager could view a dashboard which displayed the team's completed training and a compliance percentage;- 2% of training was 'overdue'. The pharmacy manager explained that this was the annual IG training, which some team members were still finishing off. A pharmacist from another branch monitored the training and informed the team when training had to be carried out. Team members did not have regular protected training time and usually carried out training in their own time, but the pharmacy manager said he did make time for training when it was necessary. The delivery driver said she was preparing for a new delivery system 'flexiPod', which was to be introduced shortly. It used a hand-held device rather than delivery sheets to record the deliveries. She had read a new SOP in preparation for this, and a training event had been organised.

Staff were given formal reviews where performance and development were discussed and received positive and negative feedback informally from the pharmacy manager. Communication within the company was via the intranet and there was an online alerting system, 'Merlin' which highlighted when new information was available such as messages from the SI's office and alerts and recalls. Daily, weekly and monthly tasks were assigned via this system. There was a notice board in the back area with posters showing targets and performance against them and a weekly bulletin 'This week in Well'. Informal 'huddles' were held, usually twice weekly, where a variety of issues were discussed, and concerns could be raised. These included updates on the pharmacy's performance against targets. At the last huddle the pharmacy manager discussed the pharmacy's texting service which informed people their prescription was due to be ordered or ready to be collected. A dispenser said she felt there was an

open and honest culture in the pharmacy, and she was comfortable admitting and discussing errors. She would talk to the pharmacy manager or regional development manager (RDM) about any concerns she might have. There was a whistleblowing policy on display in the pharmacy managers office, and a 'speak up' notice in the staff area which provided details on how to raise concerns in confidence. Staff had completed an online colleague survey where they were given the opportunity to give their thoughts on their working environment. The results were on display in the pharmacy managers office and he confirmed he had discussed the results with the team.

The pharmacy manager said he felt empowered to exercise his professional judgement and could comply with his own professional and legal obligations. For example, refusing to sell a pharmacy medicine containing codeine, because he felt it was inappropriate. Targets were set for Medicines Use Reviews (MURs) and New Medicine Service (NMS), which were closely monitored by the organisation. The pharmacy manager said there was some pressure, but he managed this, and he delegated tasks to other members of the team when it was appropriate. He said patients always came first and he didn't feel targets ever compromised patient safety.

Principle 3 - Premises ✓ Standards met

Summary findings

The pharmacy generally provides a suitable environment for people to receive healthcare services. It has a private consultation room that enables it to provide members of the public with the opportunity to have confidential conversations.

Inspector's evidence

The pharmacy was spacious and the retail area was clean, well maintained and professional in appearance. The back area and staff facilities were not as clean or as well maintained, and the flooring in some of this area was worn and stained. There was a separate stockroom where excess stock was stored and some offices. Staff facilities included a staff room with kitchen area, and two WCs with wash hand basins and antibacterial hand wash. There was a separate dispensary sink for medicines preparation with hot and cold running water. Hand washing notices were displayed above the sinks. Hand sanitizer gel was available and disposable gloves were worn when assembling MDS. The temperature and lighting were adequately controlled. Maintenance problems were reported to Well support centre and the response time was appropriate to the nature of the issue.

There was a waiting area with two chairs near to the medicine counter. The consultation room was accessed through a door from the retail into the back area. The pharmacy manager explained that nothing with patient details was stored in the area in-between the retail area and the consultation room to avoid breaching patient confidentiality. The consultation room was used when carrying out services such as MURs, and also when customers needed a private area to talk. It was equipped with a sink, but it wasn't used and a board had been placed on top to provide extra bench space when carrying out vaccinations. The room was not very tidy and the flooring was worn which compromised the professional image.

Principle 4 - Services ✓ Standards met

Summary findings

The pharmacy offers a range of healthcare services which are easy for people to access. It sources, stores and supplies medicines safely. And it carries out some checks to ensure medicines are in good condition and suitable to supply. Services are generally well managed, so people receive appropriate care and the pharmacy team members are helpful and give healthcare advice and support to people in the community.

Inspector's evidence

The pharmacy had an automatic door and was accessible to all, including patients with mobility difficulties and wheelchair users. There was a hearing loop in the pharmacy and a sign indicating this. A list of the services provided by the pharmacy was shown in the practice leaflet and some were advertised in the pharmacy. There was a corner of the retail area which contained a healthy living notice board, a range of healthcare leaflets and a self-service diagnostic testing machine which people could use to measure their height, weight, body mass index (BMI), blood pressure (bp), heart age and body composition. The pharmacy had a bp and atrial fibrillation testing device, which had been provided by the local Clinical Commissioning Group (CCG). The pharmacy manager explained that people who had high bp readings on the self-service machine were usually tested again on the CCG's device and referred to their GP if necessary. The pharmacy sometimes ran special bp testing events when lots of people were tested but normally at least one or two people were tested each week. Around one thousand flu vaccinations were carried out in preparation for the previous flu season (NHS and private). The pharmacy offered the Lipotrim weight management programme where people visited every week for support. Around six people were currently being helped in this programme. Team members were clear what services were offered and where to signpost people to a service not offered. Some signposting and healthy living interventions were recorded on 'PharmOutcomes'. Around thirty people were provided with emergency medication during August 2019, as part of the NHS emergency supply service, when a lot of local residents were evacuated from their homes because of the risk of a reservoir overflowing. The pharmacy was also forced to close for nine days during this time because of flood risk. The pharmacy manager was proactive in promoting pharmacy in the community and carried out presentations for various groups such as the Women's institute (WI), schools and churches.

The pharmacy offered a prescription collection service. Some patients were contacted before their prescriptions were due each month, to check their requirements and some patients indicated their requirements in advance when they collected their medication. Requirements were checked again at hand-out and any unwanted medicines were retained in the pharmacy and the prescription endorsed as not dispensed. This was to reduce stockpiling and medicine wastage. There was a home delivery service with associated audit trail. Each delivery was recorded but signatures were not always obtained from the recipient, which could limit the information available in the event of an incorrect delivery or problem. A note was left if nobody was available to receive the delivery and the medicine was returned to the pharmacy.

The dispensary was spacious and the work flow was organised into separate areas with a designated checking area. The dispensary shelves were well organised, neat and tidy. Dispensed by and checked by boxes were initialled on the medication labels to provide an audit trail. Different coloured baskets were

used to improve the organisation in the dispensary and prevent prescriptions becoming mixed up. The baskets were stacked to make more bench space available. Large print was available on dispensing labels. This facility was currently used by around five partially sighted patients. Tablets were popped out of their foil packaging and supplied weekly in bottles for some people with compliance difficulties. One person was blind, so it was important that the braille was not covered by the medication label. Special requirements such as these were recorded on the patient's medication record (PMR). The pharmacy manager had meetings at the local medical practice on a monthly basis, discussing topical issues such as stock availability.

Stickers were put on assembled prescription bags to indicate when a fridge line or CD was prescribed and new medicines were highlighted. 'Pharmacist' stickers were used to highlight when counselling was required and high-risk medicines such as warfarin, lithium and methotrexate were targeted for extra checks and counselling. INR levels were always requested and discussed as part of MURs if the patient was prescribed warfarin, although they were not routinely recorded when dispensing warfarin prescriptions. The team were aware of the valproate pregnancy prevention programme. An audit had been carried out and three patients in the at-risk group had been identified. The pharmacy manager had discussions with these patients about pregnancy prevention and there was a note on their PMR confirming this. The valproate information pack and care cards were not available, but the pharmacy manager said he would print them off if necessary, to ensure people in the at-risk group were given the appropriate information and counselling. He pointed out that most packs now had the care cards built into the packaging. Around nine people had been referred for gastroprotection as part of an audit of patients prescribed non-steroidal anti-inflammatory drugs (NSAIDs).

The pharmacy provided multi-compartment compliance aid packs for a large number of community and care home patients. They were assembled and checked in a dedicated room in the back area which was well organised, neat and tidy. There was a form to record communications with GPs and changes to medication. However, this was not consistently used so it was not always clear who had confirmed the changes, which could cause confusion in the event of a query. Medicine descriptions were usually included on the packaging to enable identification of the individual medicines and packaging leaflets were included, so patients and their carers had easy access to information about their medicines. Disposable equipment was used. There was a SOP for new people requesting a compliance aid pack. A suitability form was available to record an assessment made by the pharmacist as to the appropriateness of a compliance aid pack, or if other adjustments might be more appropriate to the patient's needs. This usually took place in a MUR. There was a weekly collection sheet for compliance aid packs which was completed when people collected their packs and people who had not collected were followed up and their GP was informed if non-compliance was suspected. The ACT explained that she accuracy checked all compliance aid packs, but there was no record of any clinical check being carried out by a pharmacist. There was a space to record the clinical check on the patient's record sheets, but this was not being completed. The ACT said if changes were made to the pack, she would record this, but would not necessarily obtain a new clinical check from the pharmacist, so there was a risk that the change might not be clinically appropriate.

A dispenser explained what questions she asked when making a medicine sale and when to refer the patient to a pharmacist. She was clear which medicines could be sold in the presence and absence of a pharmacist and understood what action to take if she suspected a customer might be abusing medicines such as a codeine containing product.

CDs were stored in a CD cabinet which was securely fixed to the floor. Date expired and patient returned CDs were segregated and stored securely. Patient returned CDs were destroyed using denaturing kits. Pharmacy medicines were stored behind the medicine counter so that sales could be

controlled. Recognised licensed wholesalers were used to obtain medicines and appropriate records were maintained for medicines ordered from 'Specials'. No extemporaneous dispensing was carried out.

Medicines were stored in their original containers at an appropriate temperature. Date checking was carried out and recorded electronically. Short dated stock was highlighted. Expired medicines were generally segregated and placed in designated bins. Dates had been added to opened liquids with limited stability, but these were not always removed from stock when they had expired. For example, there was a bottle Oramorph solution with a three-month expiry when opened, which had been opened in June 2019 and so was now out-of-date. The pharmacy manager said it would be removed and destroyed and said it must have been missed when the liquids were last date checked. The pharmacy was not compliant with the Falsified Medicines Directive (FMD). They had completed training on the system and had the software and hardware needed but were not currently scanning to verify or decommission medicines. They were waiting for advice from head office before commencing this. Alerts and recalls were received via 'Merlin' from the superintendent's office and could also be viewed directly from the intranet. These were read and acted on by the pharmacist or member of the pharmacy team and then filed.

Principle 5 - Equipment and facilities ✓ Standards met

Summary findings

Members of the pharmacy team have the equipment and facilities they need for the services they provide. They maintain the equipment so that it is safe and use it in a way that protects privacy.

Inspector's evidence

Current versions of the British National Formulary (BNF) and BNF for children were available and the pharmacist could access the internet for the most up-to-date information. For example, the electronic medicines compendium (eMC), which was used to print off patient information leaflets for people, and Stockleys which was used to check drug interactions.

There were two clean medical fridges. The minimum and maximum temperatures were being recorded daily and had been within range throughout the month. All electrical equipment appeared to be in good working order and had been PAT tested. Equipment was ordered through the Well support centre at head office and any problems with equipment (including IT) would be dealt with by them.

There was a selection of clean liquid measures with British Standard and crown marks. Separate measures were marked and used for methadone solution. The pharmacy also had a range of clean equipment for counting loose tablets and capsules. The pharmacy did not have separate equipment for cytotoxic drugs, but a member of the team explained that all the cytotoxics they supplied were obtained in foil strips so handling of the medicines was not necessary. Medicine containers were appropriately capped to prevent contamination.

Computer screens were positioned so that they weren't visible from the public areas of the pharmacy. PMRs were password protected. Individual electronic prescriptions service (EPS) smart cards were used appropriately. Cordless phones were available in the pharmacy so staff could move to a private area if the phone call warranted privacy.

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.