General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Well, 4 Park Lane, Poynton, STOCKPORT, Cheshire, SK12 1RE

Pharmacy reference: 1085171

Type of pharmacy: Community

Date of inspection: 15/08/2019

Pharmacy context

This is a community pharmacy in the centre of the village of Poynton, Stockport. The pharmacy sells over-the-counter medicines and dispenses NHS prescriptions. It also dispenses private prescriptions. The pharmacy team offers advice to people about minor illnesses and long-term conditions. And it offers services including medicines use reviews (MURs), flu vaccinations, a substance misuse service and the NHS New Medicines Service (NMS). It also supplies medicines in multi-compartmental compliance packs to people living in their own homes. And it has a self-service machine which allows people to collect their medicines 24-hours a day.

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	4.1	Good practice	The pharmacy's services are easily accessible to people, including people using wheelchairs. And the pharmacy offers people a choice to access their medicines at any time of day or night from the pharmacy's self-service machine. It has a health-check machine so people can monitor their health. And the team are good at advising people how they can live a healthy lifestyle.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance ✔ Standards met

Summary findings

The pharmacy has suitable processes and written procedures to protect the safety and wellbeing of people who access its services. It mostly keeps the records it must have by law and keeps people's private information safe. The pharmacy team members have the knowledge necessary to protect the welfare of children and vulnerable adults. And they have some processes and training in place to support them. The pharmacy team members try to learn from any errors they make whilst dispensing. And they take steps to help make sure the errors are not repeated.

Inspector's evidence

The pharmacy had a large open plan retail area which led up to the pharmacy counter and on into the dispensary. It had a private consultation room to the side of the pharmacy counter. The responsible pharmacist used the bench closest to the pharmacy counter to do final checks on prescriptions. This helped him supervise and oversee sales of over-the-counter medicines and conversations between team members and people at the counter.

The pharmacy had a set of standard operating procedures (SOPs). And these were held electronically. The superintendent pharmacist's team reviewed each SOP every two years on a monthly rolling cycle. This ensured that they were up to date. The pharmacy defined the roles of the pharmacy team members in each SOP. The SOP showed who was responsible for performing each task. The team members said they would ask the pharmacist if there was a task they were unsure about. Or felt unable to deal with.

The pharmacy had a process to record near miss errors that were spotted during dispensing. The final checker typically spotted the error and then informed the dispenser that they had made an error. The dispenser made a record of the error onto an electronic reporting system called Datix. The records contained details such as the date of the error and the team members involved. The team members had recently discussed the importance of entering their errors straight away to make sure they did not forget to do so. And, they took responsibility for their own errors. They discussed any errors with each other while they were making the entries on Datix. This was to allow them to learn from each other. The near miss errors were analysed each month for any trends and patterns. And the findings were discussed with the team in a monthly team meeting. The team members made several changes to prevent errors happening again. These included attaching alert stickers in front of medicines that had been commonly involved in picking errors. The pharmacy documented the details of the analysis for future reference. It had a process to record dispensing errors that had been given out to people. And it recorded these incidents on Datix. A copy of the report was sent to the superintendent pharmacist's office for analysis and kept in the pharmacy for future reference. The pharmacy had recently supplied a person with a medicine that had expired. The team members ensured they improved the organisation of the date checking process to prevent a similar error happening again.

The pharmacy had a poster on display which advertised how people could make comments, suggestions and complaints. It detailed the company head office address, email and telephone number. The pharmacy collected feedback from people through an annual survey and mystery shopper visits. But the team was unable to provide any examples of how they improved the pharmacy's services following feedback.

The pharmacy had up-to-date professional indemnity insurance. The responsible pharmacist notice displayed the correct details of the responsible pharmacist on duty. Entries in the responsible pharmacist record complied with legal requirements. The pharmacy kept complete records of private prescription and emergency supplies. The pharmacy kept the certificates of conformity of special supplies. But they were not completed correctly as required by the Medicines and Healthcare products Regulatory Agency (MHRA). The pharmacy kept controlled drugs (CDs) registers. They were in order including completed headers, and entries made in chronological order. The pharmacy team checked the running balances against physical stock each week. The running balance of Zomorph 10mg tablets was checked and it matched the physical stock. The pharmacy kept complete records of CDs returned by people to the pharmacy.

The team held records containing personal identifiable information in areas of the pharmacy that only team members could access. Confidential waste was placed into a separate bin to avoid a mix up with general waste. The confidential waste was destroyed periodically. The pharmacy explained how they stored and protected people information via a poster displayed in the retail area. The team members understood the importance of keeping people's information secure. And they had all completed training on information governance. They renewed their training each year via an online training system.

All the team members had completed training on safeguarding vulnerable adults and children via the online training system. And the regular pharmacist had completed additional training via the Centre for Pharmacy Postgraduate Education. The team members gave several examples of symptoms that would raise their concerns. And they said they would discuss their concerns with the pharmacist on duty, at the earliest opportunity. The team members had no guidance readily available to them to help them properly manage and report a potential concern. But they did have the contact details of the local safeguarding teams. And they said that they would contact the local safeguarding teams for advice if they had any concerns. The team members had recently assisted a person who was showing signs of dementia. They made sure the person's prescription was ordered on time, so they did not miss any doses.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough suitably skilled team members to manage the services it provides. It reviews staffing levels to ensure they remain appropriate. The team members openly discuss ways to improve ways of working. And they regularly talk together about why mistakes happen, and how they can make improvements. The pharmacy supports its team members to ensure their knowledge and skills are up to date. It achieves this by providing its team members with a regular training programme and appraisals of performance. The team members tailor their training to help them achieve personal goals. And to make sure they have the necessary skills for their roles. They feel comfortable to raise professional concerns when necessary.

Inspector's evidence

At the time of the inspection, the team members present were the regular pharmacist, a full-time accuracy checking technician (ACT), two part-time pharmacy assistants, a full-time pharmacy assistant and a part-time trainee pharmacy assistant. A part-time counter assistant, a part-time pharmacy assistant and two delivery drivers were not present during the inspection. The team members did not take time off in the few weeks before Christmas. As this was the pharmacy's busiest period. The pharmacy could call on the help of team members from other local Well branches to cover planned and unplanned absences. The pharmacist explained that staff rotas had been recently reviewed after staff hours had been reduced. And some team members had changed their working hours to fill in some gaps to ensure staffing levels were at an appropriate level. The pharmacist was seen supervising the team members. And they involved the pharmacist in offering advice to people who were purchasing over-the-counter products for various minor ailments. They carried out tasks and managed their workload in a competent manner. The team members accurately described the tasks that they could and could not perform in the pharmacist's absence.

The team members were able to access the online training system to help them keep their knowledge and skills up to date. They received training modules to complete every month. Many of the modules were mandatory to complete. The team members were also able to voluntarily choose a module if they felt the need to learn about a specific healthcare related topic, or needed help carrying out a certain process. The team members did not receive set time during the working day to allow them to complete the modules. A team member said she preferred to complete the modules in her own time, without any distractions. The team member showed she had completed 98 percent of the mandatory modules. The pharmacy had an annual performance appraisal process in place. The appraisals were an opportunity for the team members to discuss what parts of their roles they felt they enjoyed and which parts they felt they wanted to improve. They could give feedback on how to improve the pharmacy's services. And discuss their personal development. But the team was not able to provide any examples.

The team held monthly formal meetings and discussed topics such as company news, targets and patient safety. If a team member was not present during the discussions, they were updated the next time they attended for work. The team members openly and honestly discussed any mistakes they had made while dispensing and discussed how they could prevent the mistakes from happening again. The team recently discussed medicines that looked or sounded alike (LASAs). The team members said that these medicines were more likely to be involved in errors. And they highlighted the medicines they had more errors with. For example, amlodipine and amitriptyline, atenolol and allopurinol. The team

members had also separated some medicines on the dispensary shelves to reduce the risk of them being selected in error. For example, Epilim liquid and Epilim syrup.

The team members said they were able to discuss any professional concerns with the manager or with the company head office. The pharmacy had a whistleblowing policy. So, the team could raise a concern anonymously. The pharmacy set several targets for its team to achieve. These included services and prescription volume. The team members were well supported to help them achieve the targets. And they were not put under any pressure to achieve them.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is secure, clean and properly maintained. It provides a suitable space for the health services provided. And, it has a suitable room where people can speak to pharmacy team members privately.

Inspector's evidence

The pharmacy was clean and appeared professional. The building was easily identifiable as a pharmacy from the outside. The benches in the dispensary were kept tidy throughout the inspection. Floor spaces were clear with no trip hazards evident. There was a clean, well-maintained sink in the dispensary for medicines preparation and staff use. There was a WC which had a sink with hot and cold running water and other facilities for hand washing. The pharmacy had a sound-proofed consultation room which contained adequate seating facilities. The room was smart and professional in appearance and was signposted by a sign on the door. The room was kept locked when not in use. The temperature was comfortable throughout the inspection. Lighting was bright throughout the premises.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy offers an extended range of choice for people to access their medicines. And the pharmacy premises are easily accessible, including for people using wheelchairs. People can make use of the pharmacy's health check equipment to help monitor their health. And the team members are good at supporting people with healthy lifestyle advice. The team members take steps to identify people taking high-risk medicines. And, they provide people with advice to help them take these medicines safely. The pharmacy sources its medicines from licenced suppliers. And it generally stores and manages it medicines appropriately. The pharmacy mostly manages the risks associated with dispensing medicines into multi-compartmental compliance packs but it doesn't always provide people with patient information leaflets as required.

Inspector's evidence

The pharmacy had level access from the street to an automatic door. Large print labels were provided on request. The team members had access to the internet. Which they used to signpost people requiring a service that the team did not offer. The pharmacy advertised its services and opening hours in the front window. Seating was provided for people waiting for prescriptions. The pharmacy had a health check machine in the retail area. The machine was free for people to use. The machine took four minutes to measure a person’s body mass index, blood pressure, body fat percentage and heart age. The team members said it was very popular and was used several times each day. The machine sent people who used it an email with a summary of the report. The team often helped people who needed the report explaining to them. And they used these opportunities to advise people on the importance of regular exercise and maintaining a balanced diet.

The pharmacy was one of a few Well pharmacies to have a self-service vending machine installed. The machine allowed people to collect their dispensed medicines at any time, even when the pharmacy was closed. Each team member had completed training on how to use and manage the machine. The training was provided by Well and the external contractor who manufactured and provided maintenance of the machine. The team members had access to a SOP and a manual which they could use if they had any issues with its operation. They had also visited another Well branch that had the machine installed for several months to see how it worked. And give the team the opportunity to ask any questions. People who were interested in using the machine were required to complete a form to give their consent for their medicines to be stored in the machine and for the pharmacy to send a text message to indicate their prescription was ready for collection. The team assessed whether a prescription was suitable to be stored in the machine. Bulky items such as food supplements, CDs and fridge items were not kept in the machine. Once a prescription was deemed suitable for storage in the machine and consent had been obtained, it was identifiable using alert stickers, and the prescription was dispensed. Once checked the medicines were bagged up and sealed using tape and a barcoded bag label. The bag was taken into the room which housed the machine and the barcode was scanned using the machine’s computer system. The bag was placed into a plastic box and stored in the machine. The system automatically sent a text message to the person informing them that their prescription was ready to be collected and they had four days to do so. The text message included a four-digit passcode. When people attended to collect their medicines, they were required to enter the passcode onto a touch sensitive screen, located at the front of the building. The passcode was linked to their medicines

and the correct bag was dispensed via a chute. The layout of the screen could be altered to help people using wheelchairs and the information on the screen could be changed into various languages.

The team members regularly used various stickers that they could use as an alert before they handed out medicines to people. For example, to highlight interactions between medicines or the presence of a fridge line or a controlled drug that needed handing out at the same time. The team members signed the dispensing labels to indicate who had dispensed and checked the medication. And so, a robust audit trail was in place. The dispensary had a manageable workflow with separate areas for the team members to undertake the dispensing and checking parts of the dispensing process. Baskets were available to hold prescriptions and medicines. This helped the team stop people's prescriptions from getting mixed up. The team had a robust process to highlight the expiry date of CD prescriptions awaiting collection in the retrieval area. Owing slips were given to people on occasions when the pharmacy could not supply the full quantity prescribed. One slip was given to the person. And one kept with the original prescription for reference when dispensing and checking the remaining quantity. The team attempted to complete the owing the next day. The pharmacy kept records of the delivery of medicines from the pharmacy to people. The records included a signature of receipt. And so, an there was an audit trail that could be used to solve any queries. A note was posted to people when a delivery could not be completed. The note advised them to contact the pharmacy.

The pharmacy had recently introduced a new system of dispensing many of the prescriptions it received, at the company's offsite dispensing hub. The system was designed to reduce the team's dispensing workload and allow the team members more time to offer services such as medicine use reviews. Each team member had received comprehensive training before the process went live. The team firstly assessed whether a prescription was suitable to be dispensed at the hub. Any prescriptions that were for CDs or fridge items were not sent. The team also avoided sending prescriptions for more urgent items such as antibiotics. Once it was established that a prescription was suitable to be sent to the hub the data was inputted into the system. The pharmacist then performed an accuracy and clinical check. Only the pharmacist, using their personal smart card and password, was able to perform the clinical and accuracy check and release prescriptions to the hub. The details of the prescription were then sent electronically to the hub. And the prescription was dispensed via dispensing robots. It took three days for prescriptions to be processed and the medicines to be received from the hub. The team marked all prescriptions that were sent to the hub and stored them in a separate box to prevent them being mixed up with other prescriptions. The pharmacy received the medicines that had been dispensed at the hub in sealed bags. The bags were then coupled with the relevant prescription. And then scanned on the shelves in the prescription retrieval area, ready for collection. The pharmacist had carried out a quality assurance audit of the first 300 prescriptions that were dispensed and returned to the pharmacy via the hub. The pharmacist had physically opened the sealed bags and completed a check of all the medicines. No errors were found during the audit. A daily quality assurance audit was in place. The pharmacist chose a sealed bag that had been received from the hub at random and undertook a check. But the pharmacy did not record the details of these daily checks. And any issues were to be reported to the company's superintendent's office. The team had not encountered any issues to date.

The pharmacy often dispensed high-risk medicines for people such as warfarin. The pharmacist often gave the person additional advice if there was a need to do so. And the team recorded details of the conversations if they were significant, for example a discussion about a change in dose or directions. The team were aware of the pregnancy prevention programme for people who were prescribed valproate. The team said they were aware of the risks. And they demonstrated the advice they would give people in a hypothetical situation. The team had access to literature about the programme that they could provide to people to help them take their medicines safely. The team had completed a check

to see if any of its regular patients were prescribed valproate. And met the requirements of the programme. No people had been identified. The pharmacy used clear bags to store dispensed insulin. This allowed the team member and the person collection to undertake a final visual check of the medicine before the person collected the medicine.

The pharmacy supplied medicines in multi-compartmental compliance packs for people living in their own homes and living in three local care homes. And the pharmacy supplied the packs to people on either a weekly or monthly basis. The team members were responsible for ordering the person's prescription. And they did this around a week in advance. And then they cross-referenced the prescription with a master sheet to ensure it was accurate. The team members queried any discrepancies with the person's prescriber. The team members recorded details of any changes, such as dosage increases and decreases, on the master sheets. They dispensed the packs in a first-floor room. This was to make sure they weren't distracted while dispensing. The packs had backing sheets which listed the medicines in the packs and the directions. The pharmacy did not supply any information to help people visually identify the medicines. For example, the colour or shape of the tablet or capsule. It also did not routinely provide patient information leaflets with the packs. This is not in line with requirements.

Pharmacy only medicines were stored behind the pharmacy counter. The storage arrangement prevented people from self-selecting these medicines. Every three months, the pharmacy team members checked the expiry dates of its medicines to make sure none had expired. And records were seen. The pharmacy used stickers to highlight stock that was within six months of expiring. Some short-dated stickers were seen on items on the dispensary shelves. No out-of-date medicines were found following a random check. The team members recorded the date liquid medicines were opened on the pack. So, they could check they were in date and safe to supply. The pharmacy had a robust procedure in place to appropriately store and then destroy medicines that had been returned be people.

The team were not currently scanning products or undertaking manual checks of tamper evident seals on packs, as required under the Falsified Medicines Directive (FMD). The team had received training on how to follow the directive. The pharmacy had FMD software and scanners installed. The team was unsure of when they were to start following the directive. Drug alerts were received via email to the pharmacy and actioned. The alerts were printed and stored in a folder. And the team kept a record of the action it had taken. The pharmacy had three fridges. But the team did not always check and record the temperatures for each fridge daily. And so, the pharmacy could not always be sure that the medicines were fit for purpose.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy's equipment is clean and safe, and the pharmacy uses it appropriately to protect people's confidentiality.

Inspector's evidence

The pharmacy had copies of the BNF and the BNF for children for the team to use. And the team had access to the internet as an additional resource. The pharmacy used a range of CE quality marked measuring cylinders. The team used tweezers and rollers to help them dispense multi-compartmental compliance packs. The fridges used to store medicines were of an appropriate size. And the medicines inside were organised in an orderly manner. The vending machine was serviced and maintained regularly by an external contractor. All the electrical equipment looked in good condition and was working. Prescription medication waiting to be collected was stored in a way that prevented people's confidential information being seen by members of the public. And computer screens were positioned to ensure confidential information wasn't seen by people. The computers were password protected to prevent any unauthorised access. The pharmacy had cordless phones, so the team members could have conversations with people in private

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.