General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Well, 276 Manchester Road, WARRINGTON, Cheshire, WA1 3RB

Pharmacy reference: 1085523

Type of pharmacy: Community

Date of inspection: 05/11/2019

Pharmacy context

This is a community pharmacy next to a medical centre in a residential area of Warrington, Cheshire. It dispenses both NHS and private prescriptions and sells a range of over-the-counter medicines. The pharmacy team offers advice to people about minor illnesses and long-term conditions. And it provides services including a home delivery service, seasonal flu vaccinations, a substance misuse service and medicines use reviews (MURs). It also supplies medicines in multi-compartmental compliance packs to people living in their own 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 identifies and manages many of the risks associated with the services it provides to people. And it has a set of up-to-date written procedures for the team members to follow to help them deliver the services safely. It keeps the records it must have by law. And it keeps people's private information secure. It acts on the feedback it receives from people who use the pharmacy to improve services. The team members discuss and record any mistakes they make when dispensing. So, they can learn from each other. And they implement changes to minimise the risk of similar mistakes happening in the future. The team members know when and how to raise a concern to safeguard the welfare of vulnerable adults and children.

Inspector's evidence

The pharmacy had a small retail space which led to a large dispensary. The pharmacy counter prevented access from the retail area to the dispensary. The area was open plan and the pharmacist on duty used a dispensary bench that was adjacent to the retail area to complete final checks on prescriptions. So, she could over see any sales of medicines and listen in to any conversations the pharmacy's team members were having with people who used the pharmacy. The pharmacy had a constant flow of people coming with prescriptions that had been issued from the adjacent medical centre.

The pharmacy had a set of standard operating procedures (SOPs). And these were held electronically. They included ones for responsible pharmacist regulations and dispensing. 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 team members described how they would ask the pharmacist if there was a task they were unsure about. Or felt unable to deal with. The superintendent pharmacist's team sent new and updated SOPs to the team via the eExpert training programme. The team members completed a short quiz once they had read the SOP. They needed to pass the quiz to be signed off as having read and understood its contents.

The pharmacy recorded near miss errors made while dispensing onto a paper near miss log. And records were seen dating back to September 2019. The team had recorded two errors on the day of the inspection. The team members did not record every error and the records were lacking in detail. For example, they did not record the learning points or the reason the errors had occurred. And so, they may have missed out on some learning opportunities. They were also required to enter each record onto an electronic reporting system called Datix. But this process was rarely completed. The team members explained they did not have the time to do so. The pharmacist or the pharmacy's manager completed an analysis of the errors that had been recorded each month. This was to identify any trends or patterns. And the findings were discussed with the team when most of the team members were working. Those team members who were not working, were informed when they next attended for work. The pharmacist had noticed some errors where the team had mixed up 'solostar' and 'doublestar' Toujeo insulin. To prevent the error happening again, the pharmacist made each member aware of the potential for the mix up and to take extra care when dispensing, as the two versions were almost identical in appearance. The pharmacy used the Datix system to record details of dispensing incidents which had reached the patient. The pharmacy had recently supplied a person with the incorrect

strength of a medicine. It kept records of the nature of the error and why it had happened. But there was no record of any action the pharmacy had taken to reduce the risk of the error happening again.

The pharmacy displayed the details of its complaints procedure via a notice in the retail area. A team member described the complaints procedure and how she would escalate the complaint to the pharmacy's head office if necessary. The pharmacy welcomed feedback from people. And it collected the feedback through verbal conversations between people and the team members and an annual patient satisfaction survey. The pharmacy often supplied medicines to people that had been dispensed at a central dispensing hub. The team members explained that this had often caused confusion and some people were unhappy with the time taken for the dispensed medicines to be returned to the pharmacy. To improve, the team were spending more time explaining the service to people and ensuring they knew the option to opt out of the service.

The pharmacy had up-to-date professional indemnity insurance. The responsible pharmacist notice displayed the name and registration number 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 controlled drugs (CDs) registers. And they were completed correctly. The pharmacy team checked the running balances against physical stock every week. A physical balance check of Sevredol 10mg matched the balance in the register. The pharmacy kept complete records of CDs returned by people to the pharmacy. The pharmacy held certificates of conformity for unlicensed medicines and they were completed in line with the requirements of the Medicines & Healthcare products Regulatory Agency (MHRA).

The team were aware of the need to keep people personal information confidential. And they were seen offering the use of the consultation room to people to discuss their health. They had all undertaken general data protection regulation (GDPR) training. The team held records containing personal identifiable information in areas of the pharmacy that only team members could access. A privacy policy was on display for people to read in the retail area. Confidential waste was placed into a separate bin to avoid a mix up with general waste. The confidential waste was periodically destroyed via a third-party contractor.

The team members had up-to-date guidance on safeguarding the welfare of vulnerable adults and children available to them. Both the regular pharmacist and a pharmacy technician had completed formal training via CPPE up to level two. And they had recently refreshed their learning by completing further training. The other team members had completed training via the eExpert online training system. But they gave several examples of symptoms that would raise their concerns in both children and vulnerable adults. A team member explained how she would discuss her concerns with the pharmacist on duty, at the earliest opportunity. The pharmacy had a chaperone policy on display close to the consultation room.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy team members have the appropriate qualifications and skills to provide the pharmacy's services safely and effectively. They work well together to manage their workload and to ensure people receive a high-quality service. The pharmacy team members complete regular training to keep their knowledge and skills up to date. And they are provided with appraisals to discuss their performance and training needs. They can make suggestions to improve the pharmacy's services. And they feel comfortable to raise professional concerns when necessary.

Inspector's evidence

At the time of the inspection the full-time regular pharmacist was supported by a full-time pharmacy manager, a full-time pharmacy technician and two part-time pharmacy assistants. Another full-time pharmacy assistant was not present during the inspection. The pharmacy manager organised the team rotas in advance to ensure enough support was available during the pharmacy's busiest times. The pharmacy had recently revised the staffing profile and there had been a reduction in hours. The team members had found the changes challenging but were supporting each other well to manage the workload. They were seen managing the workload well during the inspection and waiting times were around ten minutes or less. Some team members worked overtime to cover absences and holidays and could take the time back in lieu. But this was not always possible. The pharmacy had previously employed a full-time accuracy checking technician (ACT). The ACT had not been replaced. This pharmacy was able to ask for some relief ACT support particularly to help them complete checks of the multi-compartmental compliance packs.

The team members were able to access the online training system, eExpert, 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 day to allow them to complete the modules. A team member said she completed some training when the pharmacy was quiet but this was rare and so she completed the modules in her own time, without any distractions. Each team member had completed over 90% of the modules that were mandatory. The pharmacy had an annual appraisal process. 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. For example, the pharmacy technician had implemented a new process to flag up people who were eligible for the NHS new medicines service.

The team attended ad-hoc, informal meetings and discussed topics such as company news, targets and patient safety, when the pharmacy was quiet. If a team member was not present during the discussions, they were updated the next time they attended for work. The team members felt comfortable to give feedback or raise concerns with the regular pharmacist or the pharmacy's regional development manager, to help improve the pharmacy's services. The pharmacy had a whistleblowing policy. The team was set various targets to achieve. These included the number of prescription items they dispensed and the number of services they provided. The team members were not currently meeting the targets and felt some, but not significant, pressure to achieve them.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is kept secure and is well maintained. The premises are suitable for the services the pharmacy provides. It has a sound-proofed room where people can have private conversations with the pharmacy's team members.

Inspector's evidence

The pharmacy was clean, tidy and professional in appearance. The building was easily identifiable as a pharmacy from the outside. The dispensary was generally tidy and well organised during the inspection but there were several multi-compliance packs that had not been sealed on a side bench. Floor spaces were kept clear to minimise the risk of trips and falls. There was a fire exit which led to the rear of the building. The door was kept closed to prevent unauthorised access.

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. There was a sink in the staff area used for drink and food preparation.

There was a good-sized, soundproofed consultation room at the front of the retail area. The room was smart and professional in appearance and was signposted by a sign on the door. The room contained some confidential material, for example flu vaccination consent forms. But the room was kept locked when not in use and the team did not leave people in the room unattended. The temperature was comfortable throughout the inspection. Lighting was bright throughout the premises.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's services are easily accessible to people. The team members take steps to identify people taking high-risk medicines. And, they provide these people with advice to help them take these medicines safely. The pharmacy provides some medicines in multi-compartmental packs to help people take them correctly. And it manages most of the risks associated with the service. But sometimes the pharmacy team members are behind with this workload. And this puts them under pressure and may increase the risk of errors. The pharmacy sources its medicines from licenced suppliers. And it stores and manages its medicines appropriately.

Inspector's evidence

The pharmacy had access via a ramp from the street to an automatic entrance door. And so, people with prams and wheelchairs could enter the pharmacy unaided. The pharmacy could supply people with large print dispensing labels if needed. A hearing loop to help people with a hearing impairment was available in the consultation room. The pharmacy advertised its services and opening hours in the main window and on the pharmacy's website. It had a small healthy living zone close to the seating area in the retail space. And there were several healthcare related leaflets available for people to select and take away with them.

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. 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 for 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. But the pharmacy did not always obtain consent from people to allow it to dispense their medicines away from the pharmacy. The importance of this was discussed with the team. 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 entered. And then the pharmacist completed 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 around 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 pharmacy had completed 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. She had identified one error where the pharmacy had received a bag intended for another Well pharmacy. The error was reported to the company's head office.

The pharmacy supplied medicines in multi-compartmental compliance packs for around 300 people living in their own homes. And it supplied the packs to people on either a weekly or monthly basis. The team was responsible for ordering people's prescriptions. And this was done around a week in advance to give the team members the time to resolve any queries, such as missing items or changes in doses, and to dispense the medication. They dispensed the medication on a bench furthest away from the retail area. This was to minimise distractions. The pharmacy managed the workload over a four-week cycle. The team aimed to complete the dispensing of the packs around a week before the pack was due to be supplied. But this was not always possible. The team members explained they were often having to dispense the packs on the day they were due. On the day of the inspection, the pharmacist was required to check nine people's packs before the delivery driver arrived at 10.30am. And she was regularly asked to break off from her checking process to deal with other tasks, such as telephone queries. The team received some support from a relief ACT who worked at least half a day per week. The pharmacy kept master sheets which the team members used to check off prescriptions and confirm they were accurate. It also kept details of any changes to people's medicines. And it kept records of who had authorised the change, for example, the person's GP. The packs were supplied with information which listed the medicines in the packs and the directions. But they were not supplied with information to help people visually identify the medicines. For example, the colour or shape of the tablet or capsule. The pharmacy routinely provided patient information leaflets with the packs.

The pharmacy dispensed high-risk medicines for people such as warfarin. The team members used alert stickers attached to people's medication bags to remind them that the bag contained a high-risk medicine. They then brought the bag to the attention of the pharmacist. The pharmacist gave the person collecting the medicine additional advice if there was a need to do so. The team members were aware of the pregnancy prevention programme for people who were prescribed valproate and of the risks. 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-one had been identified.

Pharmacy medicines (P) were stored behind the pharmacy counter. So, the pharmacist could supervise sales appropriately. The medicines in the dispensary were generally stored tidily. But some drawers were cluttered, and medicines were not stored in order. For example, different strengths of diltiazem were not stored together and different medicines beginning with 'T' such as tramadol, tranexamic acid, trazadone and trimethoprim were not properly segregated. This increased the risk of selection errors. The risks were discussed with the team members. Every three months, the team members checked the expiry dates of its medicines to make sure none had expired. No out-of-date medicines were found after a random check. And the team members used alert stickers to help identify medicines that were expiring within the next 12 months. They 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 by people. And the team had access to CD destruction kits.

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 some training on how to follow the directive and had the correct type of scanners. 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 checked and recorded the fridge temperature ranges every day. And a sample checked were within the correct ranges. It had two CD cabinets in place. And they were secured and of an appropriate size. The medicines inside were well organised.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy's equipment is well maintained and appropriate for the services it provides. The pharmacy uses its equipment 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 members used tweezers and rollers to help 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. 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. The electrical equipment looked to be in good working order.

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.