General Pharmaceutical Council

# Registered pharmacy inspection report

**Pharmacy Name:** Well, 11 Market Place, DISS, Norfolk, IP22 4AB

**Pharmacy reference:** 1086113

**Type of pharmacy:** Community

**Date of inspection:** 01/03/2023

## Pharmacy context

This community pharmacy is in the centre of Diss amongst other high street retail outlets. Its main activity is dispensing NHS prescriptions, some of which are delivered to people's homes. It supplies some people's medicines in multi-compartment compliance packs to help people take their medicines at the right times. And the pharmacy offers seasonal flu vaccinations. Its team members can do blood pressure checks for people. And the pharmacy provides emergency hormonal contraception under a Patient Group Direction.

## Overall inspection outcome

✔ **Standards met**

**Required Action:** None

Follow this link to find out what the inspections possible outcomes mean

## Summary of notable practice for each principle

| Principle | Principle finding | Exception standard reference | Notable practice | Why |
|---|---|---|---|---|
| **1. Governance** | Standards met | N/A | N/A | N/A |
| **2. Staff** | Standards met | N/A | N/A | N/A |
| **3. Premises** | Standards met | N/A | N/A | N/A |
| **4. Services, including medicines management** | Standards met | N/A | N/A | N/A |
| **5. Equipment and facilities** | Standards met | N/A | N/A | N/A |

## Principle 1 - Governance ✔ Standards met

### Summary findings

The pharmacy identifies and manages risks well and it has systems in place to monitor and review risks on an ongoing basis. The pharmacy's team members understand their roles and responsibilities including when they should refer people to the pharmacist for healthcare advice. And the pharmacy keeps the records it needs to by law. There are good procedures in place to protect people's information. And the pharmacy team members understand the role they play in safeguarding vulnerable people.

### Inspector's evidence

The pharmacy team had access to standard operating procedures (SOPs) issued by the pharmacy's head office to help deliver services safely and these were reviewed regularly. These were accessed via a digital portal to which team members had individual log-ins. The staff had read the SOPs relevant to their roles and there was an audit trail to show this had happened. When updated SOPs were issued, such as the safe delivery of medicines, there was a process to make sure all team members had read the revised procedures.

Team members initialled prescription labels at the dispensing and checking stages to create an audit trail showing who had been involved in these tasks. Baskets were used to keep prescriptions for different people separate and different coloured baskets were used to prioritise the workload. The dispensing benches were kept tidy to reduce risks during the dispensing process. Medicines which looked or sounded similar, for example atenolol and amitriptyline, were kept on designated shelves in the dispensary. The storage locations were highlighted with warning messages so the team members would be particularly careful when choosing the items for dispensing.

There were record sheets available to write down dispensing mistakes the team members made that were spotted before the medicines were handed out (referred to as near misses). Records about these were made on an ongoing basis. At quieter times, the details were transcribed on to an electronic reporting system so the pharmacy's head office could analyse the data for any patterns and trends and share this with the pharmacy. Dispensing incidents where medicines had been handed out to patients (referred to as dispensing errors) were also recorded and reported to the pharmacy's head office. Staff discussed any dispensing incidents as a team and the outcome of any analysis so they could learn and improve from these events. These were covered under a monthly patient safety review and there was evidence seen of these reviews occurring in practice each month. Some prescription items were dispensed at an off-site hub pharmacy and returned to this pharmacy for collection or delivery to people. The pharmacy manager completed routine quality spot checks of items dispensed at the hub so the local pharmacy could be assured that the right medicines were being handed out to people. An incident had occurred on one of these prescriptions dispensed off-site and the details had been shared with the hub so the matter could be investigated fully.

Members of the team could explain what they could and couldn't do when a pharmacist was not present. Staff members had an understanding about medicines that could be abused and restrictions on their sale. A trainee dispenser knew to refer requests for emergency hormonal contraception to the pharmacist. The pharmacy had a complaints procedure. The pharmacy manager knew about the

procedure and would report any formal complaints to head office though wasn't clear about the information they should give to people about this process. They agreed to re-read the SOP to refresh their understanding.

There were written procedures and staff training about protecting confidentiality. Sensitive information was stored out of the reach and sight of the public and confidential waste was collected separately and disposed of securely. There was a data privacy notice poster displayed in the pharmacy and information for people about how their information was handled. The IT system including the patient medication record system was password protected.

The pharmacy manager who was the responsible pharmacist (RP) during the inspection had completed level 3 training about safeguarding. Other members of staff had completed company training on this subject. There was a chaperone policy for using the consultation room. The RP could explain safeguarding issues around the covert administration of medicines to vulnerable people and understood the action they should take if approached by care home staff asking about crushing tablets.

The pharmacy had current professional liability and public indemnity insurance. Records about controlled drugs (CDs) were kept electronically and complied with legal requirements. CD running balances were kept and checked for accuracy regularly. The stock of CDs chosen at random agreed with the recorded balance. The pharmacy had a separate record for patient-returned CDs; there were none waiting to be destroyed. The RP notice was displayed where people visiting the pharmacy could see it and it showed the correct details for the RP on duty. Records about the RP were kept and were complete. Private prescriptions were recorded electronically. The prescriptions dispensed recently were checked and had been recorded. But some of the entries did not contain all the required information. Some did not include the details of the prescriber and the dates on the prescriptions were not always accurately transcribed. The pharmacy manager said they would review how these records were made.

## Principle 2 - Staffing ✔ Standards met

### Summary findings

The pharmacy has enough staff to provide its services safely and its team members have completed or are undertaking the right training for their roles. They can keep their skills and knowledge current by completing ongoing training which is provided by the company. And they can share ideas about how to improve the way the pharmacy operates.

### Inspector's evidence

At the time of the inspection, the pharmacy team comprised a pharmacy manager who was the regular RP, two trained dispensing assistants and one dispensing assistant who had nearly completed their accredited dispenser training, and a delivery driver. There were a further two trained dispensers who weren't present. The team members were able to cope with the workload throughout the visit and appeared to work well together, discussing queries whenever they arose. The trainee dispenser understood when they should refer people to the pharmacist for advice. And could describe the restrictions on the sale of medicines containing codeine or pseudoephedrine.

The company provided eLearning modules to staff to help keep their skills and knowledge current. However, staff didn't always get time to do their training at work and sometimes had to do this in their own time. Where these were considered mandatory by the company, for example information governance and other new or reviewed SOPs, there was a process to check that the team members had completed the relevant training. There was evidence that staff had completed training in the past about infection prevention and control, sepsis, and antimicrobial stewardship.

Staff described being able to discuss queries with the pharmacist or other more experienced members of staff and this was observed during the visit. The team members also felt able to share ideas to improve how the pharmacy worked. They had introduced an order book following a recent suggestion. The timings of some tasks and activities, for example preparing compliance packs, had also been changed to make best use of the skills and availability of team members. The RP said he could discuss any concerns he might have with the area manager. He felt able to exercise his professional judgement when providing services to people and he did not feel any undue pressure to meet targets.

## Principle 3 - Premises ✔ Standards met

### Summary findings

The pharmacy's premises are suitable for the services it provides to people. It generally keeps its premises clean. And it provides people with an area where they can have a conversation about their healthcare in private.

### Inspector's evidence

The pharmacy's retail area and dispensary were clean, bright, and reasonably well-maintained. Some recent repair work had been completed to deal with a leak. The fascia above the entrance door needed a thorough clean to present a better impression to people visiting the pharmacy. This was something that staff were already trying to address. There was enough space to accommodate people with prams or wheelchairs in the retail area. And there was some seating in the retail area for people waiting for services. The lighting and ambient temperature was suitable for the activities undertaken. And the pharmacy could be secured against unauthorised access. During the visit, the safety lighting and fire alarms were checked as part of a routine maintenance arrangement so they could be relied on in an emergency.

The dispensary was clearly separated from the retail space and private information on prescriptions could not be seen from the shop floor. A well-screened consultation room was accessed from the shop floor. This was large enough for the types of services the pharmacy provided and conversations in this room could not be overheard in the retail area. There was no confidential information on display in this room. In the dispensary, there was ample dispensing bench space for the volume of prescriptions handled. A section of bench was reserved for accuracy checking. And a separate bench in the back of the dispensary was used to prepare multi-compartment compliance packs to minimise risks from interruptions. There was a sink in the dispensary used for preparing medicines; this was reasonably clean though had quite a lot of calcium build-up at the base of the tap.

Staff had access to rest areas and hygiene facilities. One of the sinks used for handwashing was very badly stained; staff said they had tried but were unable to clean this properly. There was hot and cold running water available.

## Principle 4 - Services ✔ Standards met

### Summary findings

The pharmacy generally has good systems in place to make sure the services it offers are safe. It helps some people with additional needs to access its services. It dispenses prescriptions in an orderly way. And it takes extra care when it dispenses medicines which may be higher risk. The pharmacy gets its medicines from reputable sources. And it largely manages them safely so that people receive medicines which are fit for purpose.

### Inspector's evidence

The pharmacy's opening hours were displayed at the entrance. The entrance door was level with the pavement and the aisles were wide enough to accommodate people with prams or wheelchairs. There was an induction hearing loop available to assist people with hearing aids. The pharmacy displayed a range of leaflets giving people information about self-care. These included information about blood pressure checks, carer support, and online support available to help with healthy lifestyles. For people who were not able to collect their own medicines, the pharmacy offered a delivery service. There was a record kept about deliveries to show prescriptions had been delivered to the right people.

The pharmacy team members were up to date with dispensing activities. Dispensing during the visit was done in an orderly way. All dispensed items were accuracy-checked by the RP. If additional information was to be given to a person collecting medicines, a note was attached to the dispensed items. When asked, the team members knew how long prescriptions for CDs were valid for. Stickers were generally attached to some in the prescription retrieval system to help staff identify those which were beyond the valid date. And the team checked uncollected prescription items and sent reminders to people about these. Where items remained uncollected, these were returned to stock and the prescriptions sent back to the NHS spine, so people's records showed these had not been supplied. The team members knew that certain items were not suitable for sending for off-site dispensing, including items which were needed more urgently. There was also good communication with the off-site hub to inform the pharmacy about possible service disruption. This meant affected items could be dispensed locally for people, to prevent delays to their treatment.

The team members had an understanding that prescriptions for valproate needed additional care when supplying to people who might become pregnant. The stock packs available had the warning cards and alert stickers attached. The pharmacy also had spare cards and alert stickers to use if a smaller quantity needed to be supplied in a plain box. The pharmacist explained how they would check that people were aware of the need to use adequate contraception. And the pharmacy was currently completing an audit about how they managed prescriptions for valproate to identify any additional actions they needed to take to protect people. Other alert stickers to help identify prescriptions for higher-risk medicines where patient counselling was needed were available.

The dispenser could confidently explain the process for preparing multi-compliance packs. There was a rota to prepare these on time. And each person had a record about their medicines which was updated if there were any changes made. The packs viewed included dose and warning information. And descriptions of the medicines included in the packs so people could identify individual items. The pharmacy also supplied patient information leaflets with these packs every four weeks. The dispenser

could describe the types of medicines that were not suitable for inclusion in these packs.

Medicines were obtained from licensed wholesalers. Medicines were generally stored very tidily on shelves in the dispensary and CDs were stored securely. There was a process to make sure medicines were regularly date checked. When a selection of medicines was checked at random, none were found to be beyond their use-by date. But there were some bottles with handwritten labels containing loose tablets that had not been labelled with all the information needed to decide if the medicines were still safe to supply. The missing information included the batch number, expiry date, and manufacturer. The RP accepted that these should not be used for dispensing and would remove these from the shelves. Out-of-date medicines and patient-returned medicines were moved into designated bins and collected by specialist waste contractors for appropriate disposal. The medicines fridge temperatures were monitored and were kept within the required range for medicines requiring refrigeration.

The pharmacy had a process to receive and act on drug recalls and safety alerts. It was notified of these by its head office and there was a system in place to make sure these were responded to promptly.

## Principle 5 - Equipment and facilities ✔ Standards met

### Summary findings

The pharmacy team has access to the equipment and facilities it needs to provide safe and effective services to people. It has systems in place to monitor that its equipment is safe and replace it promptly if needed.

### Inspector's evidence

The pharmacy's computer screens faced away from the shop floor so that people's personal information was protected. Team members used their own smartcards to access records and electronic prescriptions and did not share these cards with colleagues. The pharmacy had access to online reference sources for clinical checks and information. There were systems in place to make sure electrical equipment and testing equipment was checked so it was suitable to use. Measuring and counting equipment of a suitable standard was available and it was kept clean. Separate counting triangles were reserved for dispensing methotrexate to prevent cross-contamination of other tablets. Gloves were also available to staff to prevent handling of these tablets.

The medicines fridges were equipped with maximum and minimum thermometers. The temperatures during the visit were within the required range for storing temperature-sensitive medicines. And the records seen showed that this had routinely been the case. One of the fridges had malfunctioned recently; the medicines had been moved to the other fridge which had sufficient space to accommodate the stock and a replacement fridge had been delivered very quickly.

## 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. |