General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Well, Wigton Medical Centre, South End, Wigton, Cumbria, CA7 9QD

Pharmacy reference: 1090266

Type of pharmacy: Community

Date of inspection: 20/02/2020

Pharmacy context

This is a community pharmacy in a medical centre in the town of Wigton, Cumbria. 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. It provides NHS services, such as the New Medicines Service (NMS) and medicine use reviews. And it provides a home delivery service.

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 has an up-to-date set of procedures to identify and manage risks to its services. The pharmacy's team members follow them to help make sure they work safely and effectively. They keep the records they must have by law. And they keep people's private information secure. The team members know when and how to raise a concern to safeguard the welfare of vulnerable adults and children. The team members discuss any mistakes that happen within the dispensing process. But they do not always keep records of the mistakes. And so, they may miss the opportunity to identify any trends or patterns and take steps to reduce the risk of similar mistakes happening again.

Inspector's evidence

The pharmacy had an open plan dispensary and retail area. The dispensary was located behind the pharmacy counter. The pharmacy counter acted as a barrier between the retail area and the dispensary to prevent any unauthorised access. The dispensary was set back far enough from the pharmacy counter to allow the team members to discuss confidential matters without being overheard by people in the retail area. The pharmacist used the bench closest to the retail area to complete final checks on prescriptions. And so, he could listen in to conversations the pharmacy's team members were having with people.

The pharmacy had a set of up-to-date electronic standard operating instructions (SOPs) in place. The superintendent pharmacist's office reviewed the procedure every two years on a monthly rolling cycle. It sent new and updated procedures to pharmacy team members via the eExpert online training system approximately each month. Once the team members had read the contents of the SOP, they completed a short quiz to test their understanding. They had to pass the quiz to be signed of as having read and understood the SOP. The pharmacy defined the roles of the pharmacy team members in each procedure. Which made clear the roles and responsibilities within the team.

The pharmacy had a process to record any near miss errors made by the team when dispensing. The team members recorded their own mistakes which helped with their learning. They entered the details of the near miss errors on to an online reporting system called Datix. But the team members did not record every near miss error that they made. They attributed this to a lack of time due to the dispensing workload. And because the pharmacy had not had a resident pharmacist since July 2019, the pharmacy was employing locum and relief pharmacists. The team members were not sure if the pharmacists were informing them about every near miss error. But if they were made aware of a near miss error, they always tried to discuss it with each other. So, they could all benefit from the learning. The near miss errors that were recorded were occasionally analysed for any trends or patterns. The team had recently focused on reducing near miss errors that involved medicines that looked or sounded alike known as LASA medicines. The team members had affixed alert stickers next to where they stored some of the LASA medicines that were most commonly involved in near miss errors. For example, quinine and quetiapine. The purpose of the alert stickers was to remind the team to take more care when they were picking the LASA medicines from the shelves. The pharmacy had a process for dealing with dispensing errors that had been given out to people. It recorded incidents on the Datix system. And kept a paper copy in the pharmacy for future reference and learning. The pharmacy had several months ago dispensed the incorrect quantity of a medicine. To prevent a similar error happening again the team members decided that a triple check would be done when the medicine was dispensed in the future.

The pharmacy had a formal complaints procedure. And it was on display in the retail area for people to see. People who used the pharmacy could discuss any concerns or complaints they had with any of the team members. And if the problem could not be resolved, it would be escalated to the pharmacy's superintendent pharmacist's team. The pharmacy collected feedback each year through questionnaires that were placed on the pharmacy counter for people to self-select and complete. The team was unable to provide any example of any improvements made in response to any feedback.

The pharmacy had up-to-date professional indemnity insurance. Entries in the responsible pharmacist record complied with legal requirements. The pharmacy kept complete records of private prescriptions and emergency supplies. It kept controlled drugs (CDs) registers. And they were correctly completed. A physical balance check of a randomly selected CD matched the balance in the register. The team completed a full balance check of the CDs every week. 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 pharmacy outlined how it handled personal and sensitive data through a privacy notice in the retail area. The team members had undertaken training on General Data Protection Regulation (GDPR). And they had completed training each year via the eExpert online training system. They were aware of the need to keep people's personal information confidential. 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 periodically collected by a third-party contractor and securely destroyed.

The responsible pharmacist had completed training on safeguarding vulnerable adults and children through the Centre for Pharmacy Postgraduate Education (CPPE). Other team members had not completed any formal training. When asked about safeguarding, the team members gave several examples of the 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 or the pharmacy's manager. If the team members needed further guidance, they explained they would contact the pharmacy's superintendent pharmacist's office for support.

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. The pharmacy team members complete training relevant to their roles to keep their knowledge and skills up to date. They can make suggestions to improve the pharmacy's services. And they feel comfortable to raise professional concerns if necessary.

Inspector's evidence

The responsible pharmacist at the time of the inspection was a relief pharmacist. He was supported by the pharmacy's manager who was an NVQ level two qualified pharmacy assistant and worked part-time, a full-time NVQ level two pharmacy assistant, a relief trainee pharmacy assistant and a full-time NVQ level three qualified pharmacy technician. The pharmacy also employed another two part-time pharmacy assistants. The pharmacy had not had a resident pharmacist for a few months. The relief pharmacist was working at the pharmacy for an average of two days per week. The remaining days were covered by locum or other relief pharmacists. The trainee pharmacy assistant was working at the pharmacy full-time to support the team while the pharmacy was recruiting for a resident pharmacist. The team members felt they had enough staff to manage the workload when there were no absences, but they felt they would be able to manage the workload more efficiently once the pharmacy had recruited a regular pharmacist.

The pharmacy provided the team members with a structured training programme. The programme involved team members completing various e-learning modules through the eExpert online system. The modules covered various topics including health and safety, new and revised SOPs and health conditions such as pain relief. Some modules were mandatory and others could be chosen voluntarily in response to an identified training need. The team members received protected training time during the working day to complete the modules. So, they could do so without any distractions. But they were not always able to take the time because of the dispensing workload. They completed training at home if they were unable to complete the training during the working day. The team members were due to receive a performance appraisal every six months. But the process had not been completed regularly.

The team members felt comfortable to raise professional concerns with pharmacist, the pharmacy manager or the pharmacy's regional development manager. The pharmacy had a whistleblowing policy. So, the team members could raise concerns anonymously. They were encouraged to give feedback to improve the pharmacy's services. but no examples were provided. The pharmacy set the team various targets to achieve. These included the number of prescription items dispensed and the number of services provided. The targets did not impact on the ability of the team to make professional judgements.

Principle 3 - Premises ✔ Standards met

Summary findings

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

Inspector's evidence

The pharmacy was clean and professional in its appearance. The building was easily identifiable as a pharmacy from the outside. The dispensary was kept tidy and well organised during the inspection and the team used the bench space well to organise the workflow. Floor spaces were generally kept clear to minimise the risk of trips and falls. There was a clean, well-maintained sink in the dispensary for medicines preparation and staff use. There was a toilet with a sink with hot and cold running water and other facilities for hand washing.

The pharmacy had a sound-proofed consultation room with seats where people could sit down with the team member to have a private conversation. The room was smart and professional in appearance and was signposted by a sign on the door. The room had a large window and there was a blind that could be used to make the room more private. 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 pharmacy mostly manages its services appropriately and delivers them safely. And it uses an offsite pharmacy dispensing hub to help manage the dispensing workload more effectively. The pharmacy obtains its medicines from reputable sources. And it mostly stores and manages its medicines safely and securely.

Inspector's evidence

The pharmacy had level access from a car park to a power assisted door. So, people with prams and pushchairs could easily access the pharmacy. The pharmacy advertised its services and opening hours in main window. And there were several healthcare related leaflets available for people to select and take away with them. For example, about flu and smoking cessation. The team members had internet access. They could use the internet to signpost people to other pharmacies or healthcare providers if they were unable to provide a service. There was a 'healthy living zone' in the retail area. The area was used to promote awareness about a healthcare related topic. And a new topic was chosen each month. At the time of the inspection the zone was displaying posters about Raynaud's disease. There was a hearing loop for people with hearing aids to use. And the pharmacy could provide large print labels to people who had a visual impairment.

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 to help manage the workflow efficiently. And they were of different colours to help the team separate different parts of the dispensing workload. For example, blue baskets were used for prescriptions for home delivery. A poster was displayed in the dispensary which outlined which colour of baskets corresponded to which part of the dispensing workload. The team members explained the poster was very useful to the locum and relief pharmacists who worked at the pharmacy. The team had a robust process to highlight the expiry date of CD prescriptions awaiting collection in the retrieval area. The team members gave people owing slips when the they could not supply the full prescribed quantity. One slip was given to the person. And one kept with the original prescription for reference when the remaining quantity was dispensed and checked. 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. So, 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 team members couldn't evidence how they obtained people's consent to dispense their medicines offsite. The importance of consent was discussed. 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. Any

prescriptions that could be sent to the hub, were kept in yellow baskets. 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. Each item on the prescription was marked with an 'H' if it was to be dispensed at the hub. On occasions, not every item on a prescription was dispensed at the hub. If any items on a prescription were not dispensed at the hub, they were marked with an 'L' which indicated the items were dispensed 'locally'. The hub assembled items using automation. It took around two or 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. Each day the pharmacist opened one randomly selected bag that had been dispensed at the hub and completed another accuracy check. This was to ensure the pharmacy completed a regular quality check.

The pharmacy dispensed high-risk medicines for people such as warfarin. The team members used 'therapy check' stickers attached to people's medication bags to remind the person handing out that the bag contained a high-risk medicine. But they didn't always use the stickers. So, some people may have not had the appropriate checks completed. The pharmacist did some basic checks with people when they came to collect their medicines. These included ensuring the person had had a recent blood test and checked their current and target INR if they were prescribed warfarin. The team members were aware of the pregnancy prevention programme for people who were prescribed valproate and of the risks. The team members used alert stickers to attach to people's medication bags to remind the person handing out that the bag contained valproate. 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. And there was an alert placed next to where valproate was stored. The alert was designed to remind the team members to check if the valproate they were dispensing was for a female person who met the criteria. The team had completed a check to see if any of the pharmacy's regular patients were prescribed valproate. And met the requirements of the programme. But the team members were not aware if any of the pharmacy's patients had been identified as meeting the requirements.

The pharmacy provided a repeat prescription ordering service. The pharmacy used cards to note down each medicine a person could order on a repeat prescription from their GP. And the person was asked which medicines they wanted to order each time they were due for their repeat prescription. The team explained this helped prevent people ordering medicines people did not need. The team members kept records of the medicines that were ordered. And the records were cross-referenced with the prescriptions to make sure they were accurate. Once the medicines had been dispensed and checked, the team members used a text messaging service to inform the patient that their medicines were ready to be collected. The team members explained the text messaging service was new and was a good way to ensure people were receiving their medicines on time, and therefore not missing any doses.

Pharmacy medicines (P) were stored behind the pharmacy counter. And in a small glass cabinet next to the pharmacy counter. The cabinet was not kept locked and people could self-select medicines in the cabinet without any assistance. The team members explained they managed the risk by ensuring one team member was always working on the pharmacy counter. So, they could intervene if anyone opened the cabinet to select a medicine. And this was seen during the inspection. The medicines in the dispensary were tidily stored. Every three months, the team members checked the expiry dates of its medicines to make sure none had expired. And the team was up to date with the process. But two out-

of-date medicines were found following a check of around thirty randomly selected medicines. The two medicines had a ‘use this pack first’ sticker attached to them. The stickers prompted the team members to check the expiry date during the dispensing process. 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 was 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. The team members were 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. The CD cabinets were secured and of an appropriate size. The medicines inside the fridge and CD cabinets 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 reference sources that included 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 fridges used to store medicines were of an appropriate size. 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 unauthorised 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.