General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Edwinstowe Pharmacy, 25 High Street, Edwinstowe, MANSFIELD, Nottinghamshire, NG21 9QP

Pharmacy reference: 1090863

Type of pharmacy: Community

Date of inspection: 30/03/2023

Pharmacy context

The pharmacy is on the high street in the village of Edwinstowe, Nottinghamshire. Its main services include dispensing NHS prescriptions, selling over-the-counter medicines and providing advice to people about their health and wellbeing. The pharmacy supplies some medicines in multi-compartment compliance packs, designed to help people remember to take their medicines. And it offers a medicine delivery service to people's 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	Good practice	1.1	Good practice	Pharmacy team members are fully engaged in identifying and managing risk. They apply continual learning from patient safety events to their day-to-day practice to help mitigate the risk of similar events occurring.
		1.2	Good practice	The pharmacy has good review processes which include regular monitoring of safety incidents. It puts controls in place to mitigate risk. These controls are kept under review to ensure they remain effective.
		1.7	Good practice	The pharmacy team uses effective monitoring tools to support it in managing people's confidential information securely. And it keeps evidence of the consent it obtains from people to support it in providing its services.
2. Staff	Good practice	2.1	Good practice	The pharmacy works to continuously monitor its workload and staffing levels. It has effective processes to support it in managing its tasks and ensuring workload pressure does not impact on the safety of its services during periods of staff absence.
		2.4	Good practice	Pharmacy team members work within a culture of openness and learning. They are enthusiastic about their roles and they work together well to achieve common goals.
		2.5	Good practice	Pharmacy team members feel empowered to share their thoughts and ideas. The pharmacy supports its team members in applying their ideas to support the safe delivery of its services.
3. Premises	Standards met	N/A	N/A	N/A
4. Services, including medicines	Standards met	4.3	Good practice	The pharmacy uses effective processes to manage its medicines. It monitors the storage environment of its medicines.

Principle	Principle finding	Exception standard reference	Notable practice	Why
management				And it has effective processes to screen and segregate patient-returned medicines at the point of receipt.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance ✔ Good practice

Summary findings

The pharmacy has good processes to identify, manage, and monitor risks associated with its services. It keeps people's confidential information secure, and it monitors how it does this. The pharmacy completes all the records it needs to by law. And it encourages feedback from people using its services. Its team members have a clear understanding of their roles and responsibilities. And they know how to recognise and respond to concerns to help keep vulnerable people safe. They engage in continual reviews to share learning following mistakes made during the dispensing process. And they use these reviews to drive improvement and to reduce the risk of similar mistakes occurring.

Inspector's evidence

The pharmacy had a range of up-to-date standard operating procedures (SOPs) designed to support its safe and effective running. The SOPs covered responsible pharmacist (RP) requirements, controlled drug (CD) management, and pharmacy services. They were due for review in July 2023 by the superintendent pharmacist (SI). They provided information about the different tasks team members could complete according to their role. For example, a dispenser had received additional training to support the medicine delivery service. The pharmacy held training records showing its team members had read and understood its SOPs. Team members demonstrated a good understanding of their own roles through volunteering information related to the tasks they undertook. And they worked effectively to identify and manage risk when completing these tasks. For example, an audit trail was used to support pharmacy technicians working in an accuracy checking technician (ACT) role. The RP recorded clinical checks on prescription forms ahead of dispensing tasks beginning. And team members took ownership of their work by completing audit trails throughout the dispensing process. This allowed ACTs to ensure they only carried out accuracy checks of work completed by others. The pharmacy had an up-to-date business continuity plan. And its team was familiar with how to access and use the plan to support the safe delivery of pharmacy services. For example, it kept bottled water for emergency use in the dispensary. This was designed to support the team in managing its dispensing services should mains water supply be unavailable. The water was labelled with appropriate use-by dates to support the team in ensuring it was safe to use.

The pharmacy had a clear culture of learning from mistakes made and identified during the dispensing process, known as near misses. And from mistakes identified after a medicine was supplied to a person, known as a dispensing incident. Pharmacy team members corrected their own mistakes during the dispensing process. The team consistently reflected on the cause of a mistake. It used a range of tools to support safe and effective dispensing, such as using notices in the dispensary to inform safety checks during the dispensing process. And it routinely identified trends in mistakes to support appropriate risk reduction strategies through its monthly patient safety review. These strategies included identifying both personal and shared learning opportunities. For example, team members felt empowered to act on identified risks by applying personal warning labels on shelf edges throughout the dispensary. These warning labels helped to prompt additional checks during the dispensing process. Team members engaged in regular exercises designed to reduce risk. For example, they refreshed their learning associated with measuring liquid medicines following a CD balance check highlighting a discrepancy of a higher-risk liquid medicine. The pharmacy had reported the discrepancy to the NHS CD accountable officer as required. A Pharmacy technician was assigned the role of 'LASA lead.' This saw them

undertake regular reviews of mistakes to help identify medicines that looked alike and sounded alike. A display in the dispensary was dedicated to raising awareness of these medicines. Team members treated these medicines with additional care by seeking a second check of their dispensing from another team member before submitting it for a final accuracy check.

The pharmacy had a complaints procedure, and this was clearly advertised within its practice leaflet. Pharmacy team members knew how to manage and escalate feedback or a concern they received. The team had responded to positive feedback about a one-way system it had introduced during the COVID-19 pandemic. It had kept elements of the system to support it in managing people's confidential information at the medicine counter. The pharmacy was registered with the Information Commissioner's Office. It had up-to-date procedures to support effective information governance. Its team members completed learning associated with these procedures. And they demonstrated how they worked to keep people's confidential information safe. For example, no person identifiable information was stored in the pharmacy's consultation room. The team held confidential waste securely and this was collected regularly for safe disposal. The manager led an information governance audit annually. The audit was repeated if a new team member commenced work at the pharmacy ahead of the annual review.

The pharmacy had appropriate indemnity insurance arrangements. The RP notice displayed the correct details of the RP on duty. A sample of pharmacy records found them to be completed in accordance with regulatory and legal requirements. There was evidence of the team carrying out and recording additional checks associated with the authenticity of prescriptions by contacting prescribers. The pharmacy kept running balances within its CD register. It checked these upon receipt and supply of a CD. And also completed regular full audits of physical stock against balances recorded in the CD register in accordance with its SOPs. A random physical balance check of a medicine conformed to the balance recorded in the CD register.

Pharmacy team members had completed learning associated with safeguarding vulnerable adults and children. They had procedures and contact information available to them to support them in reporting any concerns. The RP reflected on reporting and recording several concerns over the course of their career. The team had a good relationship with the local surgery and spoke to the surgery team when they had worries over a person's ability to take their medicines as prescribed. Pharmacy team members were aware of how to support a person requesting help through either the 'Ask for ANI' or 'Safe Space' safety initiatives, designed to support people suffering from domestic abuse.

Principle 2 - Staffing ✔ Good practice

Summary findings

The pharmacy employs a dedicated team of people with the appropriate skills and knowledge to provide its services safely. It has effective processes to manage risk when staffing levels change unexpectedly. And it supports the ongoing learning and development of its team members through regular reviews. Pharmacy team members are empowered to work to professional standards. They excel at sharing learning designed to keep people safe. And they are confident in contributing their ideas to support them in achieving this.

Inspector's evidence

The RP was the pharmacy manager. A pharmacy technician and five qualified dispensers were also on duty. One dispenser was a locum covering some leave within the team. Team members were observed supporting the locum dispenser appropriately. The pharmacy also employed two ACTs, another dispenser, a medicine counter assistant, a trainee medicine counter assistant, and a delivery driver. The atmosphere in the dispensary was calm and professional despite the potential for workload pressure being heightened due to both ACTs being absent. Pharmacy team members worked well together and fully supported the RP in their role. For example, team members bagged medicines following the final accuracy check. They were observed completing a series of checks during this stage of the dispensing process to help minimise the risk of a mistake occurring. The pharmacy had considered the risks associated with providing its delivery service, should the driver be unavailable. Another team member was trained to provide this service as part of the pharmacy's business continuity plan.

The pharmacy displayed details of its team members qualifications. Team members received regular learning time to engage in e-learning directed by the company. They also had access to training materials such as pharmacy journals and newsletters to support their learning. Registered pharmacy professionals received a day each year to support them in completing continual professional development tasks related to renewing their professional registration. All team members engaged in regular conversations with their manager about their learning and development. The RP discussed how they applied their professional judgement when undertaking pharmacy services. And they received ongoing support from team members to identify and engage with people who may benefit from specific pharmacy services.

Pharmacy team members engaged in ongoing discussions to share learning between formal team meetings. They documented the outcome of formal patient safety reviews. The team discussed how they monitored the actions it took to reduce risk to ensure they remained effective. For example, it added the double check requirement for medicines that looked alike and sounded similar in response to initial risk reduction actions stopping some, but not all mistakes involving these medicines. The pharmacy had a whistleblowing policy, and its team members knew how to raise and escalate a concern at work. They were confident in putting forward their ideas. And the pharmacy used these ideas to inform safe practices. For example, it had implemented a team member's idea of using a slip system to ensure people were served and their queries dealt with in the order they presented at the medicine counter. A team member completed the slip with the person's name and details of the service they required. They put these into baskets using numbered pegs which allowed the dispensing team to work through them in order.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy provides a professional and clean environment for delivering healthcare services. Its consultation facilities give people the opportunity to speak with a member of the pharmacy team in private.

Inspector's evidence

The pharmacy was clean and organised and it was appropriately maintained. Pharmacy team members understood how to report a maintenance concern. The pharmacy had appropriate heating arrangements. Fans provided some ventilation during warmer periods. A room thermometer supported the team in monitoring the temperature within the dispensary. Pharmacy team members had access to hand washing facilities, this included a sink in the consultation room equipped with antibacterial handwash and towels.

The public area was set out with three aisles and could be accessed by a person using a wheelchair or pushchair. The medicine counter was protected by a robust plastic screen. The dispensary was accessed up a few steps from the medicine counter, and this provided good supervision over activity taking place at the counter. It was split into two working areas. Tasks associated with higher-risk activities such as assembling medicines in multi-compartment compliance packs took place in an enclosed area of the dispensary, away from distractions. The pharmacy's consultation room was professional in appearance. Team members completed a cleaning schedule showing that the room was sanitised daily. The schedule was clearly displayed offering assurances to people that the room was maintained to a good clean standard. A staircase from the side of the dispensary led to the first-floor level of the premises. This floor provided staff kitchen and toilet facilities, a staff room, and a large storeroom. Additional storage space was available in a large room that was not part of the registered premises. Items stored in this area were appropriate.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy ensures its services are easily accessible. Its team engages well with people to help support their long-term health and wellbeing needs. The pharmacy team manages its workload effectively and it follows robust processes when dispensing medicines. It takes particular care to provide relevant information when supplying medicines to help people take them safely. The pharmacy applies effective monitoring processes to ensure medicines remain safe to use and fit for supply. And it acts with care to segregate and store waste medicines safely.

Inspector's evidence

People accessed the pharmacy up a small ramp from street level. Team members acted vigilantly when serving on the medicine counter and supported people with access when required. The pharmacy advertised its services and opening times clearly. It was advertising information related to upcoming bank holiday access arrangements, including opening hours for other local pharmacies prominently. This information could be read by people when the pharmacy itself was closed. A wall close to the entrance way was a designated 'community information zone.' It contained information about local health, community, and social care services. For example, a friendship group and a village food hub. Another part of the public area acted as a designated 'healthy living zone'. The team was currently using the zone to encourage people to adapt healthier habits by promoting alcohol awareness, an 'Eat Well' campaign and smoking cessation services through interactive displays. It referred people to a free local authority health scheme designed to support them in making positive lifestyle changes to benefit their health.

The team was committed to supporting people through the pharmacy services provided. The RP provided examples of how people had benefited from the hypertension case-finding service. On occasion the pharmacy worked with GP practices to facilitate urgent appointments for people with severely high, undiagnosed hypertension. The RP had worn the 24-hour ambulatory blood pressure monitor when preparing to provide this service. This allowed them to provide accurate information to people about what to expect when wearing the monitor. The pharmacy provided access to a range of medicines via a regional extended care service. It had up-to-date patient group directions (PGDs) to support pharmacists in supplying these medicines. The service meant people could access treatment for a range of conditions without needing to see a GP. The pharmacy received positive feedback about this service, particularly from parents of young children suffering from acute bacterial conjunctivitis.

The pharmacy protected Pharmacy (P) medicines from self-selection as it displayed them behind the medicine counter. Pharmacy team members used appropriate questioning techniques to assess requests for these medicines. And they had good awareness of the risks associated with medicines subject to abuse, misuse, and overuse, with repeat requests referred to the RP. Pharmacy team members identified higher risk medicines during the dispensing process through the use of stickers. This ensured suitable counselling took place when supplying these medicines. But they did not regularly record these types of interventions on people's medication record (PMR) to support them in providing continual care. The pharmacy completed clinical audits to support it in supplying higher-risk medicines safely. For example, it had engaged in a recent valproate safety audit with results showing compliance with the requirements of the valproate Pregnancy Prevention Programme. The pharmacy used clear

bags when assembling cold chain medicines. This prompted additional checks of the medicine against the prescription prior to supply of the medicine. The pharmacy managed prescriptions for schedule 2 and 3 controlled drugs (CDs) requiring safe custody in a designated area of the dispensary. It dispensed these at the time of supply to a person. It had effective storage arrangements for holding bags of assembled medicines containing schedule 3 CDs that did not require safe custody. These processes supported the team in ensuring it made all necessary legal and safety checks. The pharmacy kept effective audit trails associated with dispensing medicines, managing owed medicines, and delivering medicines to people's homes. The pharmacy recognised the risks associated with providing its medicines delivery service, at a distance. It had processes to support it in managing these risks including cold storage boxes in the delivery vehicle, and consent letters associated with accessing key safes when delivering medicines to vulnerable people.

The pharmacy completed suitability assessments with people prior to providing them with medicines in multi-compartment compliance packs for the first time. And it obtained ongoing consent to access people's Summary Care Records to support it in managing queries related to people's medicine regimens. The team used individual profile records for each person on the service. It kept these records up to date with details of people's current medicine regimen. It effectively recorded changes to people's medicine regimens by entering the information onto the PMR and applying a label with details of the change to the profile records. Assembled compliance packs contained dispensing audit trails and clear descriptions of the medicines inside. The pharmacy provided patient information leaflets at the beginning of each four-week cycle of compliance packs. It kept appropriate records to support it in managing the safe supply of opioid substitution medicines. And it liaised with the local substance misuse team to support the ongoing care needs of people accessing this service.

The pharmacy sourced medicines from licensed wholesalers. It stored these medicines in an orderly manner, within their original packaging. It stored some medicines in bulk, these were held in an upstairs storeroom. The medicines were subject to regular checks to ensure they remained safe to supply to people. The pharmacy had appropriate storage arrangements for medicines requiring secure storage. This included separate holding space for managing out-of-date and patient-returned medicines awaiting secure destruction. The pharmacy monitored the operating temperature range of its three fridges. Records showed that medicines were stored within the correct temperature range of two and eight degrees Celsius. And medicines were held in an organised manner within the fridges. The pharmacy team completed regular date checking tasks and it kept a record of these checks. It clearly identified short-dated medicines. A random check of dispensary and storeroom stock found no out-of-date medicines. The team annotated opening dates on bottles of liquid medicines to ensure these medicines remained fit to supply. The pharmacy had appropriate medicine waste bins and CD denaturing kits available. It screened patient-returned medicines at the time of receipt to ensure it effectively managed the risks associated with storing and disposing of these medicines. The team received medicine alerts by email. And it kept an audit trail of the checks and actions taken in response to these alerts.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has an appropriate range of well-maintained equipment and facilities for providing its services. And its team members use the equipment in a way which protects people's privacy.

Inspector's evidence

Pharmacy team members accessed written and electronic reference resources, including the internet, to support them in obtaining up-to-date information. They used NHS smartcards and password protected computers to access people's medication records. The layout of the premises effectively protected information on computer monitors from unauthorised access. The pharmacy stored bags of assembled medicines on designated shelving within the dispensary and to the side of the medicine counter. This protected personal information on bag labels from unauthorised view. Pharmacy team members used cordless telephone handsets. This meant they could move out of earshot of the public area if the phone call required privacy.

The pharmacy had a good range of clean crown-stamped measuring cylinders for measuring liquid medicines. It identified its measures for use with specific higher-risk medicines or water. This mitigated any risk of cross contamination when dispensing medicines. The pharmacy also had appropriate equipment for counting tablets and capsules, and to support the supply of medicines in multi-compartment compliance packs. Equipment used to support the delivery of pharmacy services was from recognised manufacturers. For example, the pharmacy's blood pressure monitors were on the list of monitors validated for use by the British and Irish Hypertension Society. The pharmacy had effective cleaning and maintenance regimens to ensure equipment remained safe to use. For example, its electrical equipment was subject to periodic portable appliance tests.

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.