General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Well, 23 Lawrence Avenue, Awsworth, NOTTINGHAM, Nottinghamshire, NG16 2SN

Pharmacy reference: 1091130

Type of pharmacy: Community

Date of inspection: 17/01/2020

Pharmacy context

This is a community pharmacy in a village on the outskirts of Nottinghamshire. The pharmacy sells over-the-counter medicines and dispenses NHS prescriptions and private prescriptions. It offers advice on the management of minor illnesses and long-term conditions. It supplies some people with medicines in multi-compartment compliance packs, designed to help them to remember to take their medicines. The pharmacy 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	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 the risks associated with its services. It manages people's personal information with care. It advertises and responds to feedback about its services appropriately. And it generally keeps the records it must by law up to date. Pharmacy team members understand how to recognise, and report concerns to protect the wellbeing of vulnerable people. They act openly and honestly by sharing information when they make mistakes. And they engage in review processes which help identify how they can reduce the same mistake from happening again.

Inspector's evidence

The pharmacy had a set of up-to-date standard operating procedures (SOPs). The superintendent pharmacist's team reviewed these on a rolling two-year cycle. Pharmacy team members accessed SOPs electronically. And completed learning through watching videos and completing assessments to confirm their understanding of each SOP. The dispenser on duty demonstrated her training records. And a new inductee had started to read through SOPs and was observed asking questions to confirm her understanding of the pharmacy's processes if she was at all unsure. The responsible pharmacist (RP) on duty was a locum pharmacist and explained he would access SOPs onsite if he needed to. The dispenser demonstrated a sound understanding of her role. And pharmacy team members were aware of what tasks could not be completed should the RP take absence from the premises.

The pharmacy was small. The dispensary offered enough space for managing the volume of prescriptions dispensed. There was separate space for labelling, assembling and accuracy checking medicines. And the pharmacy did send a small proportion of prescriptions to its off-site dispensing hub. And space was further managed through the pharmacy having a second room fitted out as an additional dispensary. This provided protected work space for managing the multi-compartment compliance pack service. The pharmacy dispensed medicines in these packs to local people and on behalf of two other local Well pharmacies.

The pharmacy had a near-miss error reporting procedure. This involved team members reporting mistakes on a paper record and transferring them to an electronic database 'Datix' each week. A pharmacy team member felt that most near misses were recorded. And examples of how the team responded to their mistakes by applying risk-reduction actions throughout the dispensary were demonstrated. For example, different formulations of ramipril had recently been separated on the dispensary shelves. And pharmacy team members had engaged in further learning associated with 'look a-like and sound a-like' medicines. Pharmacy team members reported dispensing incidents on Datix. The RP on duty explained how he would manage an incident. He had not had to report an incident with the company to date. But he identified how he could seek support from team members and regional support managers if he was required to manage an incident.

The pharmacy's manager printed data analysis reports monthly. These showed trends in error reporting. And the team members worked together to help identify further learning and risk reduction actions required during monthly team meetings. The manager recorded brief details of the review process each month. A pharmacy team member explained how further exploration of patient safety case studies were shared during these briefings. And these had helped inform the pharmacy's

management of some medicines more commonly involved in adverse safety events.

The pharmacy displayed a copy of its practice leaflet on its main door. This contained details of its complaints procedure. And it provided information about how the pharmacy used people's personal data. A pharmacy team member was observed taking time to speak to a person about their preferred brand of medication during the inspection. And following this conversation the team member added a note to the person's medication record to help meet this request. Pharmacy team members could explain how they would respond to a concern and they were aware of how to escalate a concern further if required. The pharmacy also engaged people in feedback through an annual 'Community Pharmacy Patient Questionnaire'.

The pharmacy had up-to-date indemnity insurance arrangements in place. The RP notice displayed reflected the correct details of the RP on duty. The sample of the RP record examined was generally completed in accordance with legal requirements. There was one sign-out time missing from the sample of the record examined. A sample of entries checked in the pharmacy's prescription only medicine (POM) register complied with legal requirements. The pharmacy held its specials records in accordance with the requirements of the Medicine & Healthcare products Regulatory Agency (MHRA).

The pharmacy maintained running balances of controlled drugs (CDs) within its CD register. And it completed full balance checks against physical stock weekly. The RP explained there was an issue with the balance of Zomorph 10mg capsules. This was because some Zomorph 10mg capsules had been placed in an unlabelled amber bottle. The balance in the register conformed to the physical balance found in the cabinet when the contents of this bottle were included. Pharmacy team members thought the bottles had been removed from a multi-compartment compliance pack prior to its supply, due to a dose change. A discussion took place about the need to clearly identify and label the bottle and mark the capsules as awaiting destruction when an authorised witness next visited. This was because the bottle contained no details of the batch number, expiry date or assembly date. All of which were required to confirm the medicine was safe and fit to supply. The RP acted to segregate and label the bottle immediately. Other physical balances of CDs checked during the inspection conformed to the balances recorded in the CD register. The pharmacy kept a patient returned CD register. And pharmacy team members wrote returns into the register on the date of receipt.

The pharmacy displayed a privacy notice. And pharmacy team members had completed learning associated with the procedures in place for managing confidential information. A new member of the team was aware of the need to protect people's personal information. The pharmacy had submitted its annual NHS Data Security and Protection (DSP) Toolkit as required. It stored all personal identifiable information in staff only areas of the pharmacy. Assembled medicines were stored in bags to the side of the dispensary, close to the healthcare counter and consultation room. There was no physical barrier between the counter and the side of the dispensary. Pharmacy team members were observed applying vigilance when speaking to people at the counter to ensure people remained in the public area of the pharmacy. Pharmacy team members transferred confidential waste to 'Shred-it' sacks. These were sealed and collected by the waste management contractor for secure disposal at periodic intervals.

The pharmacy had procedures and information relating to safeguarding vulnerable adults and children. And contact information for local safeguarding agencies was prominently displayed. It displayed a chaperone notice to people. Pharmacy team members were required to complete safeguarding e-learning .The RP had completed level two safeguarding learning through the Centre for Pharmacy Postgraduate Education (CPPE). The new team member explained how she would identify and report a safeguarding concern directly to the pharmacist. The delivery driver had a sound understanding of how he might identify vulnerable people through his role. And provided examples of how he had referred

concerns back to pharmacy teams. And a pharmacy team member explained how the team would act upon minor concerns relating to compliance issues by sharing them with a person's GP.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough skilled and knowledgeable people working to provide its services effectively. It supports the learning needs of its team members by providing opportunities for continual learning associated with their roles. Pharmacy team members engage in regular conversations relating to risk management and safety. And they record the outcomes of these conversations to help monitor the actions they take to improve safety. They are empowered to make suggestions about how the pharmacy provides its services. And they understand the processes in place designed to support them in raising concerns at work.

Inspector's evidence

On duty at the time of the inspection was the RP, a qualified dispenser and a trainee pharmacy assistant who was in her second week of employment. The pharmacist manager was on leave on the day of inspection and another dispenser was on a day off. Company employed drivers provided the pharmacy's medication delivery service. The dispenser provided some examples of how the team managed their working hours when a team member was on leave. For example, by working overtime and changing their shift pattern. Colleagues from the area relief team supported the pharmacy on occasion. The new member of the team had started directly after a dispenser had left the pharmacy. This meant there was no undue pressure on the team as staffing levels had remained consistent.

The trainee had begun by shadowing people and learning how to complete tasks associated with prescription reception and hand out. She explained she felt well supported by all team members. And the dispenser was observed taking time to go through tasks with the trainee during the inspection. For example, explaining the checks and processes involved in accepting and storing patient returned medicines. Team members completed regular e-learning. This learning was often completed in team members own time, at home. Or during lunch breaks. A pharmacy team member explained how information from newsletters and safety briefings were helpful as they provided opportunities to reflect on how other pharmacies had managed situations. The pharmacy had a structured appraisal process with all team members receiving a one-to-one with their manager to review learning and development each year.

The RP demonstrated a note which had been left for locums by the pharmacy manager. The note related to support locum pharmacists could provide in completing services such as Medicines Use Reviews (MURs). And by engaging in audits related to the NHS Pharmacy Quality Scheme (PQS). The RP was completing a MUR as the inspection began. He explained there was no undue pressure to provide services and would contribute to them when a need was identified. Pharmacy team members were aware of the targets for providing services and could demonstrate how they assisted pharmacists in identifying eligible people for services during the dispensing process. Pharmacy team members were observed referring to the RP when a person required specific information about their medicine.

The pharmacy team mainly communicated through informal team huddles. Patient safety reviews were structured and these took place monthly. The pharmacy had a whistleblowing policy in place. And members of the team on duty were aware of how they could raise and escalate a concern if required. The new team member explained she had been provided with a list of important contacts during her

first week of induction. The dispenser explained how changes to workflow were generally discussed openly and applied once all staff had contributed their ideas. For example, the team had discussed and trialled management of its offsite dispensing process before making the workflow permanent.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean, secure and maintained to the standards required. The pharmacy has private consultation facilities available for people to use.

Inspector's evidence

The pharmacy was professional in appearance and it was secure. The public area was small. It could accommodate a wheelchair or pushchair. But the pharmacy's consultation room was not accessible to people using wheelchairs. A pharmacy team member explained the pharmacy closed for lunch and as such there was some scope for a person requiring privacy to be seen during this period if they were unable to access the consultation room. This contingency arrangement had not been used to the team's knowledge to date. The consultation room was sign-posted. But the room was somewhat cluttered with paperwork and equipment which did distract from the overall professional appearance of the room.

The dispensary was small. But it was a sufficient size for the level of activity carried out. Work benches were kept free of non-work-related items. The additional space in the back dispensary provided enough room for managing the supply of medicines in multi-compartment compliance packs. This helped to manage the risks associated with this activity and provided a relatively distraction free space for dispensing. To the side of this dispensary was a small staff area and space for managing the pharmacy's medication delivery service. To the back of the pharmacy was staff toilet facilities.

Pharmacy team members reported maintenance issues to a designated help-desk. There were no outstanding maintenance issues reported at the time of inspection. The pharmacy was clean. It was heated through floor level fan heaters. And it had a portable air conditioning unit which could be used in summer months. Lighting throughout the premises was adequate. Antibacterial soap was readily available at the pharmacy's sinks along with paper towels.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy advertises its services and makes them accessible to people. It has up-to-date procedures and protocols to support the pharmacy team in delivering its services. The pharmacy keeps audit trails of prescription requests and medication deliveries. So it can deal with any queries effectively. It obtains its medicines from reputable sources. And it has some systems in place to ensure it keeps these medicines safely and securely. But it doesn't always store its medicines within their original packaging. Or follow best practice guidance when supplying medicines in non-original containers. This may increase the risk of an adverse event relating to the supply of these medicines occurring.

Inspector's evidence

There was a very small step from street level up to the pharmacy door. And pharmacy team members identified how they would support people with access if required. The pharmacy advertised its opening times and service clearly. It had a small healthy living area which was used to advertise national health campaigns. Pharmacy team members explained that most people were happy to engage in conversations about their health and wellbeing. Pharmacy team members were aware of the requirement to signpost a person to another pharmacy or healthcare provider if the pharmacy could not provide a service. Pharmacy team members discussed the popularity of some services. For example, the minor ailments scheme. The pharmacy offered an ear, nose and throat service as part of this scheme. This allowed the regular pharmacist to issue treatment for acute infections without the need for the person to visit their GP. The pharmacy had appropriate patient group directions (PGDs) in place to support its services where required.

Pharmacy team members completed a record of the prescriptions they ordered from surgeries following requests from people. This helped ensure they received prescriptions for all medication required. And it provided the pharmacy with the opportunity to chase queries with a surgery prior to a person attending to collect their medication. The pharmacy used coloured baskets throughout the dispensing process. This kept medicines with the correct prescription form and helped inform workload priority. Pharmacy team members signed the 'dispensed by' and 'checked by' boxes on medicine labels to form a dispensing audit trail. The pharmacy team kept original prescriptions for medicines owing to people. The team used the prescription throughout the dispensing process when the medicine was later supplied. The delivery driver demonstrated the audit trails for the prescription delivery service and people signed to confirm they had received their medicine, unless physically unable to. The driver explained how he would sign on behalf of these people.

The pharmacy had SOPs for managing higher-risk medicines. And pharmacy team members were knowledgeable about the requirement to request monitoring records for these medicines. Pharmacy team members explained that pharmacists would verbally counsel people on the use and monitoring requirements of medicines such as warfarin and methotrexate. And the pharmacy was engaging in PQS audits relating to medication safety. This included a valproate audit which supported the pharmacy in ensuring it met the requirements of the valproate pregnancy prevention programme (PPP). Pharmacy team members demonstrated high-risk warning cards available to issue to people in the high-risk group when dispensing valproate. A pharmacy team member explained prescriptions containing high-risk

medicines were dispensed locally and would not be sent to the off-site dispensing hub.

The pharmacy only sent a small number of its prescriptions to its off-site dispensing hub. And team members demonstrated the process for entering data. All information entered was checked by a pharmacist prior to being sent to the hub. And the RP on duty was also responsible for the clinical check of the prescription. A random sample of assembled medicines dispensed by the hub were unsealed and checked for accuracy by the pharmacy team prior to being stored on allocated shelves for collection. And the pharmacy kept an audit trail of these checks.

There was a robust process for managing the work schedule associated with the multi-compartment compliance pack service. The pharmacy had individual profile sheets for each person who received their medicines in these packs. And changes to medication regimens were generally recorded well on the profile sheet and within event diaries kept together with the sheets. A sample of assembled packs contained full dispensing audit trails and descriptions of the medicines inside the packs to help people identify them. The pharmacy supplied some patient information leaflets associated with the medicines it had dispensed. But a sample of these leaflets found they were not supplied for every medicine. A discussion took place about the requirement to supply a patient information leaflet for each medicine dispensed. The pharmacy did not always follow best practice guidance when supplying medicines with shortened shelf-lives once removed from their original packaging. A discussion took place about the risks associated with supplying these medicines and how the pharmacy team could seek further support on managing the supply of these medicines through its superintendent pharmacist's team.

The pharmacy sourced medicines from licensed wholesalers and specials manufacturers. Pharmacy team members demonstrated some awareness of the aims of the Falsified Medicines Directive (FMD), such as changes to medication packaging. But the pharmacy team was not aware of when further steps to support it in complying with the directive would be implemented.

The pharmacy stored Pharmacy (P) medicines in cabinets to the side of the healthcare counter. This protected them from self-selection. The RP had supervision of sales taking place and was able to intervene if necessary. The pharmacy generally stored medicines in the dispensary in an organised manner. But not all medicines were stored in their original packaging. Some amber bottles of medicines did not contain appropriate details of the medicines inside the bottle, including batch numbers, expiry dates and assembly dates. A discussion took place about the risks associated with storing medicines in this way. And an effort was made to remove some of the identified medicines from stock during the inspection. The pharmacy kept an electronic audit trail of its date checking processes. It was up-to-date with date checks. But some medicines, expiring at the end of 2019 had not been removed from stock. The medicines were clearly annotated to show they were short dated. And pharmacy team members were observed checking expiry dates during the dispensing process. The pharmacy annotated the opening date on to bottles of liquid medicines. This allowed them to apply checks during the dispensing process to ensure the medicine remained fit for purpose.

The pharmacy held CDs in a secure cabinet. Storage arrangements for medicines within the cabinet were orderly. The pharmacy physically marked CD prescriptions which prompted additional checks of these high-risk medicines, including each prescription's validity period. And assembled CDs were held in clear bags within the cabinet. The pharmacy's medicine fridge was an appropriate size. Stock inside the fridge was organised and easy to find. Assembled cold-chain medicines were held in clear bags. This prompted an additional check of the assembled product prior to supply. Temperature records confirmed the fridge was operating between two and eight degrees Celsius as required.

The pharmacy had medical waste bins, sharps bins and CD denaturing kits available to support the team

in managing pharmaceutical waste. The pharmacy received drug alerts through its intranet. And these alerts were regularly checked and actioned.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs for providing its services. It monitors it equipment to ensure it remains in safe working order. Pharmacy team members act with care by using the pharmacy's facilities and equipment in a way which protects people's confidentiality.

Inspector's evidence

The pharmacy had up-to-date written reference resources available. These included the British National Formulary (BNF) and BNF for Children. Pharmacy team members also had access to the internet and intranet which provided them with further resources. Pharmacy team members used NHS smart cards to access people's medication records. The pharmacy's computers were password protected and information on computer monitors was protected from unauthorised view due to the layout of the pharmacy. Pharmacy team members used cordless handsets when speaking to people over the telephone. And a team member was observed moving to the back room of the pharmacy when holding a private conversation with a member of the public about their medicine.

The pharmacy used clean, crown stamped measuring cylinders for measuring liquid medicines. This included separate cylinders for measuring methadone. Its counting equipment for tablets and capsules was clean. It had a separate counting triangle for use when counting cytotoxic medicines. Equipment in the consultation room included appropriate adrenaline supplies to support the flu vaccination service and an otoscope for supporting the ear, nose and throat service. And a blood pressure machine which had been checked within the last 6 months to ensure it was safe and fit for purpose. The pharmacy's electrical equipment had last been safety tested in August 2019.

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.