General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Click Trading Limited, Unit 3 Osbourne Court, Thelwall New Road, Grappenhall, WARRINGTON, Cheshire, WA4 2LS

Pharmacy reference: 1091303

Type of pharmacy: Closed

Date of inspection: 11/08/2022

Pharmacy context

The pharmacy is on a small industrial estate in a village close to Warrington. It has an NHS distance selling contract and so people do not access the premises directly. The pharmacy's main focus is dispensing NHS prescriptions, including supplying some people's medicines in multi-compartment compliance packs. It dispenses a large number of prescriptions from district nurses. It delivers people's medicines to their homes.

Overall inspection outcome

Standards not all met

Required Action: Improvement Action Plan

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 not all met	2.2	Standard not met	The pharmacy doesn't have a process to ensure new drivers complete the GPhC training requirements for support staff. And it has drivers working who it hasn't promptly enrolled on a suitable course.
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 adequately identifies and manages the risks with its services. It keeps people's private information safe, and it is good at listening to people's views and feedback to understand their needs. Team members understand their role in helping to protect vulnerable people. And they mostly make the records they must by law, apart from records showing which pharmacist was responsible for the running of the pharmacy and when. Team members follow processes they learn from others, but they do not have up-to-date written procedures to refer to. And they do not have complete audit trails to show they have robust processes in place.

Inspector's evidence

The pharmacy had standard operating procedures (SOPs) relevant to most of the pharmacy's services, but these were dated in 2016 and 2017 and had not been updated even though this was highlighted at the last inspection. There was a SOP for the dispensing of multi-compartment compliance packs, which had not been available at the last inspection. But the SOP was not dated and there were no training records available to evidence the SOP had been read. The delivery driver's SOP had not been updated to account for the changes during the pandemic. From a sample of training records seen, the last records were from 2017. New team members had not read the SOPs. Team members were seen working safely and there were some clear processes in place. One of the directors confirmed the review of the SOPs had been highlighted as a priority.

Pharmacy team members were seen completing appropriate tasks for their roles and referring queries to the pharmacist when needed. Team members had distinct roles, dispensing in the main dispensing area, or completing the workload associated with dispensing of medicines into multi-compartment compliance packs. One ACT completed accuracy checking in the main dispensary, whilst the other completed checks for compliance pack dispensing. There was a verbal process to ensure that prescriptions were clinically checked prior to dispensing, and this was clearly explained by the pharmacist, team members and an ACT. But there was no audit trail, or record made of completed clinical checks and the process relied on the team knowing that prescription tokens in the basket on the checking bench had been clinically checked. Similarly, the ACT knew that prescription tokens printed out for the compliance packs had been clinically checked, but there was no signature from the pharmacist to confirm this. Although one pharmacist verbally took responsibility for these clinical checks, often there were two pharmacists working and so it was not documented who had completed the clinical check in case of an error or query.

The pharmacy had paper near miss error logs to use, but there was no current one in use in the dispensing area where compliance packs were dispensed. The ACT working in this area described how they highlighted any near misses with the dispenser and asked them to rectify it. There was a historical near miss log in the main dispensary with the last entries from December 2021. There was not much detail regarding why an error happened or any actions taken. Team members informally discussed near miss errors together but didn't formally review them. The pharmacy had a SOP relating to incidents and errors, but not all the current team members had read it. They openly discussed recent near miss errors and how they had personally learnt and changed their practices. They described which medicines they had rearranged on the shelves to prevent selection errors. The ACT described how the shape and colour of a recent brand of metformin modified release mirrored that of metformin 500mg tablets and how

she had shared this knowledge with the other team members dispensing compliance packs, so they were able to answer any queries from people.

The pharmacy displayed the correct RP notice. It had a written procedure to manage complaints and team members described how they escalated any concerns to one of the pharmacist directors. The pharmacy team had a culture of listening to people's concerns so they could resolve them quickly. People had the opportunity to feedback via telephone and email, and the pharmacy provided details on the website. Several examples of positive feedback were demonstrated during the inspection, one from a driver returning from delivering. The pharmacy had a social media page, and a team member described the positive feedback received from this site.

The pharmacy had up-to-date professional indemnity insurance until December 2022. It kept up-to-date CD registers in several files for ease of use. The pharmacy completed some checks of the physical quantity against the balance in the register, and records showed checks after each receipt and supply. Not all register headers were complete. Of two physical balances checked, both matched the CD register balance. The pharmacy held electronic private prescription records. The pharmacy held an electronic RP record, but the entries were not complete, with several days where no RP had signed in. And most days the RP did not sign out. The records had improved slightly since the last inspection. One of the directors now displayed his RP notice so it was clear who was the RP if there were two pharmacists working. After discussion the director decided to revert back to a paper RP record to help meet requirements.

The pharmacy didn't have any written information for team members to refer to relating to the General Data Protection Regulation (GDPR) and they had not received formal training. Team members knew the importance of keeping people's private information secure and demonstrated this during the inspection. The pharmacy separated confidential waste from general waste, and this was removed by a third-party contractor. The RP and ACTs had previously completed CPPE level 2 safeguarding, one ACT identified that she would benefit from redoing some training. Team members understood what to do if they were concerned about a vulnerable person and described how they would refer any concerns to the RP.

Principle 2 - Staffing **Standards not all met**

Summary findings

The pharmacy's team members mostly have the qualifications they need to provide its services. But the pharmacy doesn't enrol all its team members on courses to meet the training requirements for its support staff. So, some team members may not have the knowledge to fully perform their role. Team members work well together to manage the dispensing workload. And they feel comfortable to discuss any ideas to improve services and to raise any concerns should they need to.

Inspector's evidence

The RP was one of the directors and worked full time in the pharmacy. There was often another pharmacist working for at least part of the day, usually the SI, and two full-time accuracy checking technicians (ACTs). The pharmacy had six dispensers and thirteen delivery drivers. A team member, without a formal qualification, worked part time accepting deliveries from the wholesalers. She confirmed she didn't complete any dispensing duties. Two team members working in the office, without formal qualifications, completed administration duties. The pharmacy was advertising for more staff, including another ACT. The delivery drivers worked mostly part time and delivered people's medicines to their homes. There had been a new driver starting since the last inspection and they hadn't been enrolled on a course that met the training requirements for pharmacy support staff. Drivers completed an induction when they started which involved on the job training, access to a driver's guide and shadowing an experienced driver until they were competent to work on their own.

The pharmacy had increased the number of prescription items dispensed since the last inspection. There was a degree more workload pressure than before, particularly on the RP director, who reported working longer hours than the pharmacy was open. Team members were seen working well together and completing the workload in a calm manner. Some team members wore headsets and answered the telephone quickly, usually within two to three rings. The director organised the holiday rota cover to ensure the pharmacy had enough people working. An ACT described recent learning and how they kept up to date, as part of continuous professional development (CPD). The pharmacy enrolled dispensary team members on qualification training and supported them to complete this. Team members were comfortable asking the director any questions to improve their knowledge, but the pharmacy didn't provide any ongoing training material or structured training modules to help keep the team's knowledge up to date. The pharmacy didn't have regular team meetings to discuss concerns, near miss errors and ideas for service improvement and instead had informal discussions as they worked. Team members described how approachable the director was and how they felt they would listen and act on any concerns raised. The pharmacy didn't set any targets for services. Several team members described how the emphasis was on good customer care and how the director went above and beyond to help people. This influenced team members to act in the same way.

Principle 3 - Premises ✔ Standards met

Summary findings

Overall, the pharmacy premises are suitably clean and hygienic. And they are appropriate for the services provided. The pharmacy has enough space, although some areas where it stores its medicines are untidy.

Inspector's evidence

People did not physically access the pharmacy premises due to its NHS distance selling contract. There was a notice on the entrance door for 'employees only' and the internal door into the office was kept locked. The pharmacy had a separate goods-in area that was secured when not in use. The premises were mostly clean and there were no urgent maintenance issues. There was little natural light, most areas were bright with the lighting used. A couple of areas in the main dispensary, would benefit from some additional lighting. It was hot outside, and the temperature throughout the premises was acceptable. The pharmacy was using a portable air conditioning unit.

The pharmacy had enough bench and storage space for the workload. It had increased its storage and dispensing space using a separate room as workload increased. This area was kept tidy and organised. The tidiness of the shelves in the main dispensing area was better than at the last inspection but overall, they were still untidy and not all medicines were clearly separated. The team kept benches mainly clear from clutter and it kept floors and aisle ways clear to avoid slips and trip hazards. The pharmacy had toilet facilities with hot and cold running water and separate staff facilities, which were kept clean. It had a separate sink in the dispensing area for medicines preparation.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy manages and delivers its services safely and in an organised manner, including the delivery of medicines to people's homes. And people easily contact the pharmacy to access its services. It mostly stores and manages its medicines appropriately. And it acts promptly on receipt of medicine alerts to make sure its medicines are safe to supply.

Inspector's evidence

People accessed the pharmacy's services using details from its website, by email and telephone. The pharmacy also had a social media page. The pharmacy worked closely with district nurses and dispensed a large volume of their prescriptions for dressings and appliances. It delivered these and people's medicines directly to their homes. The pharmacy stored medicines awaiting delivery in a clearly defined separate area of the pharmacy. It allocated the delivery workload by geographical location and deliveries were stored in clearly labelled totes. It was easy for drivers to see their deliveries for a particular day. The driver's process was to annotate a white board to inform the team which delivery area they were delivering in and when. The pharmacy kept urgent, same day delivery medicines separate and used an urgent sticker on the bag. This helped the delivery drivers plan their route. The pharmacy used fridge stickers. It used name and address dispensing labels on delivery sheets to inform the route and to keep a record of who they delivered to. The drivers were not asking for signatures following changes made during the pandemic and there seemed to be a number of different ways they annotated the delivery sheets. One driver explained how he annotated the sheet with the time of delivery in case of queries. The pharmacy did not have an up-to-date SOP so that all drivers worked in the same way. The pharmacy didn't keep a reference copy of the delivery sheet in the pharmacy in case of queries, this had been highlighted at the last inspection.

The pharmacy had separate areas for labelling, dispensing, and checking prescriptions. It kept prescriptions awaiting medicines from wholesalers on separate shelving and this meant the dispensing benches were not cluttered. The dispenser described a rotation of these prescriptions awaiting stock, to make sure they were dispensed and delivered in good time. The pharmacy had a separate dispensing area to the back of the premises for dispensing multi-compartment compliance packs to avoid distractions and to keep the workload separate. Pharmacy team members used baskets during the dispensing process, to help reduce the risk of error. The pharmacist had discussed the requirements for dispensing valproate with the team since the last inspection and he had checked who the pharmacy dispensed valproate to, to check if any interventions were necessary.

The pharmacy dispensed medicines into multi-compartment compliance packs for a large number of people. There were dedicated team members, including an ACT who managed this workload for the prescriptions received monthly. There had been few changes in managing the service since the last inspection. People had an electronic medication record indicating which medicines were to be dispensed into the packs and at what times. An ACT demonstrated how this was kept up to date and the checks she made on receipt of prescriptions. Team members supplied patient information leaflets (PILs) with the packs once a month. They kept a full audit trail of when people's prescriptions were due to be ordered and when the compliance packs were delivered. This was a colour-coded paper audit trail according to when different week's people's medicines were due. The information was printed and kept in full view, so it was easy to recognise which prescriptions were outstanding. The pharmacy dispensed

some people's medicines into an automatically timed compliance device. It hadn't formally assessed the risks with providing the service and it didn't have a SOP. Some people received the inner plastic containers, which relatives or carers inserted into the device themselves. These were supplied with non-tamper evident plastic seals and so medicines could be moved before sealing in the device, without the knowledge of the pharmacy. Other medicines were supplied fully sealed in the device with the times set and batteries inserted. One of the pharmacists organised this workload. The ACT described an organised process they followed and demonstrated how they used a dispensing aid to help ensure the right medicines went in the right slots. The pharmacy supplied some compliance packs from weekly prescriptions and this dispensing was segregated in a separate room. The organisation and tidiness of this room had much improved from the last inspection and was a suitable area from which to provide the service.

The pharmacy obtained its medicines from licensed wholesalers. It stored medicines requiring cold storage in a medical fridge and kept an electronic daily record of fridge temperatures. But the thermometer had broken on the day of the inspection and the RP confirmed it was on his list of priorities to action that day. The temperature in the fridge had been recorded as being within the correct range on the previous days. The pharmacy had a second fridge in the delivery area, but this did not have a thermometer to monitor the temperature. This had been highlighted at the last inspection. The SI confirmed his intention to order an additional thermometer to rectify this. The pharmacy only kept medicines awaiting delivery in the second fridge for a short time.

The pharmacy had a date checking record, and there had been records since the last inspection. It was not up to date, the last record being January 2022. No out-of-date medicines were found from a sample checked. The pharmacy kept some of its medicines in the compliance pack dispensing area outside of the original manufacturer's original packs. All containers had the medicine, strength, form and batch number and expiry detailed on the pack. This was much improved from the last inspection. The pharmacy had medicinal waste bins available for returned medication and denaturing kits for CDs. The pharmacy had appropriate processes to action medicine recalls and safety alerts. Signed and dated printed copies of the alerts were seen for recent medicine recalls.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide its services. And it uses its equipment in a way that suitably protects people's privacy.

Inspector's evidence

The pharmacy had reference resources and access to the internet for up-to-date information. It had password-protected computers and the team used NHS smart cards. People couldn't view confidential information on the screens as the pharmacy had no windows in the dispensing areas and unauthorised people couldn't access the premises. Team members used headsets, and this allowed them to have private conversations with people. The pharmacy had consumables suitable for the compliance pack dispensing service and stored them appropriately. It had suitable glass measuring cylinders.

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.