General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Weelsby View Pharmacy Ltd, Weelsby View Health Centre, Ladysmith Road, GRIMSBY, South Humberside, DN32 9SH

Pharmacy reference: 1091700

Type of pharmacy: Community

Date of inspection: 27/02/2020

Pharmacy context

This is a busy community pharmacy set within the grounds of a health centre in Grimsby, North East Lincolnshire. The pharmacy sells over-the-counter medicines and it dispenses NHS and private prescriptions. It offers advice on the management of minor illnesses and long-term conditions. The pharmacy also provides a medicines 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 generally identifies and manages the risks associated with its services. It keeps people's private information secure and it advertises how people can provide feedback about its services. Its team members understand how to recognise, and report concerns to protect the wellbeing of vulnerable people. The pharmacy mostly keeps the records it is required to by law. But it doesn't undertake regular audits of quantities associated with some of its records. This may make it more difficult to manage a query should one arise. Pharmacy team member discuss their mistakes. But they don't always record them. This may mean there are some missed opportunities to share learning.

Inspector's evidence

The pharmacy had a set of up-to-date standard operating procedures (SOPs). The SOPs had been issued within the last two years and contained details of an annual review date. On the day of inspection SOPs were accessible electronically. But SOPs relating to responsible pharmacist (RP) requirements and controlled drug (CD) management were not available in the SOP folder on the pharmacy's computers. The supervisor explained hard copies of the SOPs had been removed from the pharmacy for review pending an upcoming inspection from NHS England. The SOPs were recalled during the inspection and this confirmed that relevant RP and CD management SOPs were in place. Pharmacy team members were asked to sign a training record associated with SOPs to confirm they had read and understood them. Copies of training records associated with SOPs were seen. But some newer team members had not signed to confirm they had read them. The supervisor explained all staff were due to re-read and sign a new training record.

SOPs included roles and responsibilities of pharmacy team members. And the pharmacy team members on duty were observed working in accordance with SOPs. A member of the team clearly explained what tasks could not take place if the RP took absence from the premises. And other team members demonstrated tasks associated with managing services. For example, completing audit trails associated with the managed repeat prescription service.

Workflow in the dispensary was managed reasonably well. There was dedicated bench space for processing acute and managed work. And the RP had protected space for completing accuracy checks of medicines. Managed workload was accuracy checked by the pharmacist and then bagged by another member of the team. Team members bagging checked medicines were observed checking details of the medicine against the prescription and bag label during this process. They explained this introduced an additional check to the dispensing process to help manage risk.

A pharmacy team member explained that the RP would ask her to look again at her work, should she make a mistake during the dispensing process. But the pharmacy only recorded significant near misses or near misses which were picked up when the team member who made the mistake was not on duty. This meant there were opportunities for personal learning. But due to not recording all near misses there were some missed opportunities for shared learning. The pharmacy recorded its dispensing incidents in a book. And details of incidents were sent to the pharmacy's superintendent pharmacist for investigation. An example of learning following an incident was demonstrated. The learning had involved addressing the risks associated with not following a person's delivery instructions.

The pharmacy didn't routinely record the actions it took to reduce risk following adverse events. And this meant there were limited opportunities to measure the effective of any actions taken. But Pharmacy team members could demonstrate how they acted to reduce risk. For example, they had applied some high-risk warning labels to shelf edges in the dispensary to prompt additional checks during the dispensing process. And some medicines with similar names had been moved away from each other on the dispensary shelves. For example, amlodipine and amitriptyline. A pharmacy team member explained how three people were involved in the dispensing of a controlled drug. And she explained how an extra check by a second team member ahead of the accuracy check helped improve safety related to dispensing these higher risk medicines.

The pharmacy had a complaints procedure in place. And pharmacy team members explained how they would respond to a concern. And provide the superintendent pharmacist's contact details to people who wished to escalate their concerns. The pharmacy's practice leaflet provided further details of how people could raise a concern or provide feedback about the pharmacy or its services. And the pharmacy also promoted feedback through its annual 'Community Pharmacy Patient Questionnaire'. A member of the team explained that feedback was largely positive. And explained how team members from the dispensary would support on the medicine counter when the public area got particularly busy. This helped reduce feedback relating to the time taken to be served.

The pharmacy had up-to-date indemnity insurance arrangements in place. The RP notice contained the details of the RP on duty. But the notice contained the RP's historic registration number with the Royal Pharmaceutical Society of Great Britain. And not his current registration number. A discussion took place about the need to ensure the information displayed on the notice related to the current register of pharmacy professionals. Entries in the responsible pharmacist record complied with requirements. The pharmacy maintained running balances in its CD register. It completed some balance checks of stock upon receipt and supply of CDs. But no full balance checks had taken place in recent years. This meant it could be more difficult for the pharmacy to investigate and resolve a discrepancy should one occur. A physical balance check of Physeptone 5mg tablets complied with the balance recorded in the register. The register was maintained in accordance with legal requirements. The pharmacy kept a patient returned CD register. And it generally recorded returns into the register on the date of receipt. The pharmacy's Prescription Only Medicine (POM) register was kept up to date. But entries relating to private prescriptions included only the name of the prescriber and not the prescribers address as required. The pharmacy kept completed certificates of conformity associated with the supply of unlicensed medicines.

The pharmacy stored people's personal information in staff only areas of the pharmacy. And pharmacy team members demonstrated how their working processes kept people's information safe and secure. All team members had completed some learning relating to confidentiality requirements. The pharmacy had submitted its annual NHS Data Security and Protection toolkit as required. It disposed of confidential waste by using a cross shredder. But there was a build-up of confidential waste waiting to be shredded on the day of inspection. This was stored in the dispensary and away from unauthorised access.

The pharmacy had procedures and information relating to safeguarding vulnerable people in place. Contact information for safeguarding teams was available for its team members to refer to. The RP had completed level two safeguarding training. And other members of the team confirmed they had read procedures associated with safeguarding. But not all team members had completed learning on the subject. Pharmacy team members spoken to about safeguarding discussed how they would manage a hypothetical scenario by monitoring it and bringing it to the attention of the RP. And team members

could discuss the types of concerns they would refer to the RP.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough people working to provide its services effectively. It promotes how its team members can provide feedback. And it acts on their feedback appropriately. It assists with the continual learning needs of its team members through ongoing training. And pharmacy team members engage in regular conversations relating to managing their work load and patient safety.

Inspector's evidence

On duty at the time of the inspection was the RP (full-time regular pharmacist), five qualified dispensers (one of which was the pharmacy's supervisor), a medicine counter assistant, a trainee dispenser and a trainee stock management assistant. The pharmacy also employed another medicine counter assistant, a trainee medicine counter assistant and another trainee dispenser. Trainee team members were enrolled on accredited training courses associated with their roles. Two company employed drivers provided the medication delivery service. And there was some flexibility in staffing levels to help cover leave.

Pharmacy team members were observed working within their scope of competencies. They referred to the RP for support when required. It was reported that a medicine counter assistant provided some minor stock management support to the dispensary team. A discussion took place with the supervisor about the need to ensure any person completing such tasks was enrolled on and working towards the relevant modules of a GPhC accredited training course. And the supervisor confirmed the team member could support with other, administrative tasks instead. The RP explained the pharmacy did not set any specific targets for services. His attention and priority was on managing the dispensing service. A member of the pharmacy's management team attended the pharmacy to complete Medicines Use Reviews (MURs) with people.

Team members confirmed they had access to some continual learning. This involved reading information relating to medicines and minor ailments. And e-learning relating to healthy living. The supervisor was in the process of renewing her accuracy checking dispenser qualification. Trainee members of the team confirmed they felt well supported by other team members. But team members reported they completed the majority of their written learning at home due to how busy the pharmacy was. Pharmacy team members engaged in one-to-one feedback with a member of the pharmacy's management team periodically.

Day-to-day feedback mechanisms were mainly informal. Pharmacy team members discussed workload and patient safety issues as they arose. The supervisor recorded details of concerns and incidents in a book. And these events were discussed with the team to help share learning. The pharmacy had a whistleblowing policy in place. And pharmacy team members confirmed they were confident to feedback any concerns or ideas. And they knew how to escalate concerns if necessary. Pharmacy team members demonstrated changes in the way the pharmacy managed its Electronic Prescription Service (EPS) prescriptions. The changes applied had been staff led. And they had helped improve the efficiency of the service.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is secure and maintained to the standards required. People using the pharmacy can speak with a member of the pharmacy team in confidence in a private consultation room.

Inspector's evidence

The pharmacy was secure. Pharmacy team members reported maintenance concerns to the owner. And local contractors were used to manage any issues. The pharmacy was generally clean. But there was some areas of clutter. This included paperwork and items which had not been used for some time. Work benches were clear of non-work-related items and floor spaces were free from trip hazards. Antibacterial soap and towels were available at designated hand washing sinks. The pharmacy was air conditioned. And lighting throughout the premises was sufficient.

The public area was a good size. It was large and relatively open plan. To the side of this area was a signposted consultation room. The room was also used to complete some administration tasks such as ordering repeat prescriptions. Personal identifiable information was removed from the room between these tasks being completed. There was enough space in the room to hold a private consultation. But some files and paperwork stored in the room did distract from its overall professional appearance.

The dispensary was accessed from the side of the medicine counter. It was a sufficient size for the level of activity taking place. And workflow was sufficiently managed. To the back of the dispensary was access to staff facilities and a large stock room. The stock room was kept in an orderly state.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's services are accessible to people. It has suitable procedures to support its team members in delivering its services effectively. And the pharmacist takes time to speak to people about their medicines. The pharmacy obtains its medicines from reputable sources. It generally manages its medicines safely. But there is a reliance on some informal processes to support team members in doing this. This could mean it is more difficult for the pharmacy to show how it considers and manages risk associated with handling its medicines should an adverse event occur.

Inspector's evidence

The pharmacy was accessible through a push/pull door level at street level. And there was onsite parking available to people. There was designated seating provided for people waiting for a prescription or service. The pharmacy displayed its opening times. And it advertised the services it provided. A television screen above the consultation room door provided further details of some of the pharmacy's services. Pharmacy team members understood the requirement to signpost people on to another healthcare provider or pharmacy, should the pharmacy not be able to provide a service or a medicine.

The pharmacy had some processes to help its team members manage the supply of high-risk medicines. This involved the pharmacist providing verbal counselling when handing out medicines. But the opportunity to record details of these conversations and any associated monitoring checks on people's medication records was not taken. The RP demonstrated how completing some continual professional development about acute kidney injury had increased the quality of advice provided when dispensing prescriptions for trimethoprim and nitrofurantoin. People receiving prescriptions for these medicines were provided with a handout. The handout provided guidance on fluid intake associated with maintaining kidney health. Pharmacy team members were aware of the risks associated with the supply of valproate to females. The pharmacy had resources associated with the valproate Pregnancy Prevention Programme (PPP). And a conversation took place about updated information relating to PPP and the requirement to issue a valproate warning card when dispensing valproate to females.

The pharmacy used 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 copies of prescriptions for medicines owing to people. And it used the prescription throughout the dispensing process when the medicine was later supplied. It retained an audit trail for its prescription collection service. This allowed team members to monitor the service and ensure it received the correct prescriptions for people. It kept an audit trail for the prescription delivery service. But people were only asked to sign for deliveries of controlled drugs. This meant it could be difficult for the pharmacy to resolve a query about the delivery service if one arose.

The pharmacy sourced medicines from licensed wholesalers and specials manufacturers. Pharmacy team members discussed changes to medicine packaging introduced due to the Falsified Medicine Directive (FMD). But they were not aware of any plans associated with working towards compliance with FMD requirements. Some of the pharmacy's SOPs had been updated to include FMD information. But the pharmacy had yet to implement these changes.

The team received details of drug alerts through the NHS central alerting system. And team members demonstrated how alerts were checked. Details of the alerts were kept on the email account for reference purposes. The RP had held onto some adrenaline autopens which had been subject to a recall due to a risk of the device failing. And explained this was due to him being unable to secure a supply of replacement pens. A discussion took place about the need to source other formulations of adrenaline to support vaccination services. Or signpost on to another pharmacy or healthcare provider if supplies could not be obtained. The pharmacy had used its stock of flu vaccinations and was not providing this service on the day of inspection.

The pharmacy stored Pharmacy (P) medicines behind the medicine counter. This meant the RP had supervision of sales taking place. And the RP was observed providing advice to people purchasing these medicines. The pharmacy generally stored medicines in the dispensary in an organised manner. But it stored a small number of medicines in amber bottles rather than their original packaging. Bottles did not contain full details of the medicine inside such as batch number and expiry date. A discussion took place about the risks of storing medicines in this way. The pharmacy held CDs in a secure cabinet. Medicine storage was adequate. But the cabinet was nearing its storage capacity. Pharmacy team members could explain the validity requirements of a CD prescription and demonstrated how CD prescriptions were managed to help prompt additional checks during the dispensing process. The pharmacy had two fridges for storing cold chain medicines. A sample of temperature records confirmed they were operating between two and eight degrees Celsius as required.

The pharmacy team did not have scheduled dates for date checking. One member of the team focussed on stock management tasks and explained how stock was rotated and dates were checked regularly as stock came in. A discussion took place about the risk of missing medicines which were not commonly dispensed. A random check of stock in the dispensary found no out-of-date medicines. And pharmacy team members were observed checking expiry dates during the dispensing process. The team did not always annotate liquid medicines with their date of opening. This meant team members could not easily identify how long a bottle of liquid medicine had been opened for.

Medical waste bins and CD denaturing kits were available to support the team in managing pharmaceutical waste. But some patient returned medicines had been left in a basket on a dispensing bench overnight. The returns included some CDs. The patient returned CD register had been placed on top of the basket to enter in the returns. And the team explained the need to secure the returns had been an oversight. Immediate action was taken to secure the returns in a cabinet.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs for providing its services. Pharmacy team members manage and use 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 could access additional resources through the internet. The pharmacy's computer system was password protected. And information on computer monitors was protected from unauthorised view through the layout of the premises. Pharmacy team members used NHS smart cards to access people's medication records. The pharmacy stored assembled bags of medicines in two retrieval areas, one to the side of the dispensary and the second in a back room off the dispensary. This protected information on bag labels from unauthorised view. Pharmacy team members used cordless telephone handsets when taking phone calls. And a team member was observed moving out of ear shot of the public area with the phone when speaking to a person about their medication.

The pharmacy had a sufficient range of stamped measuring cylinders for measuring liquid medicines, including separate cylinders for use solely with methadone. But it also had a plastic, non-calibrated measure close to the sink. A discussion took place about the risk of using equipment which did not meet British Standard. And the supervisor acted immediately to remove the measure from use. The pharmacy also had clean counting equipment for tablets and capsules. The RP had a wrist blood pressure machine. This was used for screening purposes only. And people were referred to their GP if the result of the check was abnormal. Electrical equipment and wiring was visually free from wear and tear. There was no evidence of recent portable appliance checks being carried out.

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.