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: 22/11/2022

Pharmacy context

This community pharmacy is next door to a large health centre in Grimsby. The pharmacy's main activities are dispensing NHS prescriptions and selling over-the-counter medicines. It offers a range of services including the seasonal flu vaccination service and blood pressure monitoring. And it delivers medication to some people in their 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	2.5	Good practice	The pharmacy is good at encouraging team members to share ideas on how to improve the delivery of services. And they actively engage in providing feedback on any changes that may affect their ways of working.
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 suitably identifies and manages the risks associated with its services. It has written procedures that the pharmacy team generally follows. And it completes all the records it needs to by law. The pharmacy mostly protects people's private information correctly and the pharmacy team has training and guidance to respond to safeguarding concerns. The team members, on most occasions, respond correctly when errors occur. They discuss what happened and they take appropriate action to prevent future mistakes. But they don't always keep full records of errors to review and improve their practice.

Inspector's evidence

The pharmacy had a range of standard operating procedures (SOPs). These provided the team with information to perform tasks supporting the delivery of services. The pharmacy had new SOPs covering the automated dispensing unit that had been installed a week earlier and the automated prescription collection point. The team had read the SOPs and signed most of the SOPs signature sheets to show they understood and would follow them. But the signature sheets for new SOPs had not been signed by the team. The team members demonstrated a clear understanding of their roles and worked within the scope of their role.

The pharmacy had a procedure to manage errors spotted during the dispensing process known as near miss errors. And it had a separate procedure for errors that were identified after the person received their medicines, known as dispensing incidents. The procedures included keeping a record of the near miss errors and dispensing incidents. However, the last near miss record was made in July 2022 and the records captured contained limited details. Information such as the actions the team took to prevent the error from happening again were not always recorded. The team discussed their errors and highlighted potential errors such as medicines that looked and sounded alike. Following an incident when a person received another person's medication the team was reminded to complete the necessary checks to confirm the person's details when handing over the prescription.

The pharmacy had a procedure for handling complaints raised by people using the pharmacy services. The team introduced a form to complete when a person presented at the pharmacy for their prescription, but it was not ready to collect. The forms captured the person's details, when their prescription was ordered and the time they presented at the pharmacy. The completed form was placed in a basket for a dedicated team member to process. The team introduced this procedure after several people raised concerns that they were kept waiting longer than other people to receive their prescription.

The pharmacy had up-to-date indemnity insurance. A sample of records required by law such as the Responsible Pharmacist (RP) records and controlled drug (CD) registers met legal requirements. The pharmacy didn't regularly check the balance of the CD registers to identify errors or missed entries. The team was aware of data protection requirements and the pharmacy displayed information in the retail area advising people on how it safeguarded confidential information. And the team separated confidential waste for shredding onsite. However, several repeat prescription order forms containing people's confidential information were kept on open display in the consultation room.

The pharmacy had safeguarding procedures and guidance for the team to follow and team members had access to contact numbers for local safeguarding teams. The pharmacist had recently completed level 2 training from the Centre for Pharmacy Postgraduate Education (CPPE) on protecting children and vulnerable adults. The team responded appropriately when safeguarding concerns arose. This included liaising with the GP team when a person was having difficulty taking their medication.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has an experienced team with the qualifications and skills to support its services. Team members work very well together, and they share ideas on how to improve the delivery of services. They actively engage in providing feedback on any changes that may affect their ways of working. They benefit from identifying areas of their own practice they wish to develop, and the pharmacy helps them to achieve this.

Inspector's evidence

A full-time pharmacist and regular locum pharmacists covered the opening hours. The pharmacy team consisted of a part-time accuracy checking technician (ACT), eight full-time dispensers, one who was the pharmacy supervisor, a part-time trainee dispenser and a new starter. The supervisor had developed a team rota covering the main tasks to be completed and all team members were trained on how to undertake the tasks. This ensured the tasks were completed especially at times when team numbers were reduced such as unplanned absence.

The pharmacy provided team members with additional training on a range of subjects, for example sepsis. And it provided team members with opportunities to develop their skills and take on more roles. One of the dispensers with a good knowledge of IT systems had been recruited into the role of managing the automated prescription collection point and the automated dispensing system. And supported the other team members with training and use of these systems.

The pharmacy occasionally held team meetings and the supervisor used the one hour overlap time when team members started and ended their shift to share key pieces of information. The team had discussed with the pharmacy owners the impact significant increases in the volume of prescriptions dispensed was having on the team’s workload. And how this could be managed to ensure the safe and effective delivery of the dispensing service. The option to recruit more team members was discussed and ruled out as there was no space in the pharmacy for additional team members to work in. As a result of further discussions an automated dispensing system was planned and installed. The pharmacy owners regularly engaged with the team members throughout the planning and installation of the system to ensure there was little impact on their workload during this time.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are secure and suitable for the services provided. And the pharmacy has adequate facilities to meet the needs of people requiring privacy when using the pharmacy services.

Inspector's evidence

The team generally kept the pharmacy clean and tidy. In response to the COVID-19 pandemic the pharmacy had installed clear plastic screens on the pharmacy counter and hand sanitising gel was available. The team members used separate sinks for the preparation of medicines and hand washing. And they generally kept floor spaces clear to reduce the risk of trip hazards. The pharmacy had enough storage space for stock, assembled medicines and medical devices. And it had a defined professional area where items for sale were healthcare related.

The pharmacy had a small soundproof consultation room that the team used for private conversations with people and when providing services such as flu vaccinations. The room was cluttered and provided limited space for the team to work from and for people to move around. The pharmacy team was aware of this, and plans were in place to build a larger consultation room. The pharmacy also had a medical screen in the area housing a blood pressure machine to provide people with privacy when using the machine.

The pharmacy had de-registered the section of the retail area that housed the automatic prescription collection point. This stored completed prescriptions that didn’t include fridge line or CDs and allowed people to collect 24-hours a day, seven days a week. The pharmacy had recently installed an automated dispensing system to support the team’s increased workload and demands on storage space. This was housed to the rear of the dispensary and was designed to have minimal impact on the area the team worked in. The pharmacy had restricted public access to the dispensary during the opening hours.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides a range of services which are easily accessible for people, and it manages these services well. It uses automation to support the safe delivery of its dispensing service to ensure people receive their medicines when they need them. The pharmacy gets its medicines from reputable sources, and it stores them properly. The team regularly carries out checks to make sure medicines are in good condition and suitable to supply.

Inspector's evidence

The pharmacy had a step-free entrance and plenty of room in the retail area for people to move around. The team members used a bar-code system to scan the completion of the different stages of dispensing prescriptions. So, when a person presented, they could locate the person's prescription. The team members wore name badges so people using the pharmacy knew who they were speaking to.

The pharmacy provided the NHS seasonal flu vaccination service against an up-to-date national protocol. The pharmacist and team of trained vaccinators had signed the protocol. But they had not indicated on the signature sheet which stage in the administration of the vaccine they were involved with. People could arrange an appointment or, when capacity allowed, the team offered a walk-in service. The team provided people with clear advice on how to use their medicines. And the pharmacist contacted people who used the automated prescription collection point to provide information or advice about their medication. The team members were aware of the criteria of the valproate Pregnancy Prevention Programme (PPP) and the information to be provided. The pharmacy supported this with a SOP covering the supplies of valproate and the PPP criteria.

The pharmacy supplied medicine to some people daily as supervised and unsupervised doses. The doses were prepared in advance of supply to reduce the workload pressure of dispensing at the time of supply. The team stored the prepared doses in a CD cabinet without separating people's doses, which ran the risk of the wrong person's medication being selected. The pharmacy provided multi-compartment compliance packs to a local care home. People, living at home, requiring their medication in such packs were directed to other pharmacies close by who provided the service. The care home team was responsible for ordering the prescriptions and advised the pharmacy team of new medicines and whether the person had any medicine allergies. The pharmacy team recorded the descriptions of the medicines within the packs and supplied the manufacturer's packaging information leaflets. The pharmacy sent the packs a week before the new cycle started to allow the care home team time to check the supply.

The team members used baskets during the dispensing process to isolate individual people's medicines and to help prevent them becoming mixed up. And they used different coloured baskets to highlight for example, prescriptions to deliver and those that were urgent. This helped the team manage its workload and prioritise the dispensing of prescriptions. Most medicines were dispensed from the automatic dispensing system that the team accessed from one of four computer stations linked to the system. Each station had a chute leading from the automated system to a basket that held the dispensed medicine. The separate chutes helped to prevent a build-up of dispensed medicines in one area which could increase the risk of errors. The pharmacy had checked by and dispensed by boxes on the dispensing labels to record who in the team had dispensed and checked the prescription. A sample

found that the team completed both boxes. The pharmacist initialled the prescription token to show they'd completed a clinical check of the prescription. So, the ACT could complete their check. When the pharmacy didn't have enough stock of someone's medicine, it provided people with a printed slip detailing the owed item. The pharmacy kept an electronic record of the delivery of medicines to people and the delivery driver obtained a signature from the person receiving CDs. If the person was not at home the driver left a note advising of the failed delivery and that a further two delivery attempts would be made. People using the automatic prescription collection point were advised by an electronic message that their prescription was ready. And provided with a code to access the collection point. The code remained valid for a week, after this time the team contacted the person to advise them of this and to collect their medication when the pharmacy was open.

The pharmacy obtained medication from several reputable sources. The team members checked the expiry dates on stock and marked medicines with a short expiry date. This prompted them to check the medicine was still in date. No out- of-date stock was found. The automated dispensing unit captured the expiry dates of medicines as they were scanned into the system by the team. This ensured medicines with short expiry dates were picked first. The unit also alerted the team to medicines due to expire. The team members recorded the dates of opening for medicines with altered shelf-lives after opening so they could assess if the medicines were still safe to use. The team members checked and recorded fridge temperatures and a sample of these records found they were within the correct range. They used a device stored in the fridge to provide detailed readings of the temperatures throughout the day. The pharmacy had medicinal waste bins to store out-of-date stock and patient returned medication. It stored CDs in a cabinet that met legal requirements and the team used appropriate denaturing kits to destroy CDs. The pharmacy received alerts about medicines and medical devices from the Medicines and Healthcare products Regulatory Agency (MHRA) via email. The ACT was generally responsible for responding to the alert and taking the necessary actions.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide its services safely. And it makes sure its equipment is used appropriately to protect people's confidential information.

Inspector's evidence

The pharmacy had references sources and access to the internet to provide the team with up-to-date clinical information. It had equipment available for the services provided including a range of CE equipment to accurately measure liquid medication and two large pharmacy fridges. The computers were password protected and access to people's records restricted by the NHS smart card system. The computer on the pharmacy counter was positioned in a way to prevent disclosure of confidential information. And the team members used cordless telephones to ensure their conversations with people were kept private. The team stored completed prescriptions away from public view and held other information in the dispensary and rear areas, which had restricted public access.

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.