General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Whalley Range Pharmacy, 1 Whalley Range, BLACKBURN, Lancashire, BB1 6DX

Pharmacy reference: 1091710

Type of pharmacy: Community

Date of inspection: 08/06/2023

Pharmacy context

This is a community pharmacy in a residential area in the town of Blackburn, Lancashire. It dispenses NHS and private prescriptions and sells a range of over-the-counter medicines. The pharmacy provides the NHS hypertension case finding service, a home delivery service and dispenses some medicines in multi-compartment compliance packs to people who need support in taking their medicine correctly.

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 correctly identifies and manages the risks associated with its services. Pharmacy team members help keep people's confidential information secure and are appropriately equipped to safeguard vulnerable adults and children. The pharmacy has a process to record details of mistakes made during the dispensing process. But team members do not retain records of these mistakes. So, they may miss the opportunity to identify any specific trends or patterns.

Inspector's evidence

The pharmacy had a set of standard operating procedures (SOPs). These were digital instructions designed to support the team in safely undertaking various processes. They included SOPs for the management of controlled drugs (CDs) and dispensing prescriptions. The SOPs were reviewed every two years by the pharmacy's superintendent pharmacist (SI). The reviews were to ensure the SOPs remained up to date. Each team member signed a document to confirm they had read and understood the SOPs that were relevant to their roles.

The pharmacy had a digital system for the team to use to record details of mistakes made during the dispensing process but were spotted during the final checking stage. These mistakes were known as near misses. However, team members recorded near misses on paper as they found this easier than using the digital system. The responsible pharmacist (RP) then used the record as a reminder to discuss the near miss with other team members. Team members explained they looked to learn from each other's mistakes, and they collectively discussed ways they could improve patient safety. For example, they had recently discussed a series of near misses where team members had dispensed the incorrect form of a medicine. For example, ramipril capsules instead of tablets. They considered ways they could prevent similar mistakes from recurring and decided to store the two different forms away from each other. The team explained this measure had reduced the number of similar near miss errors occurring. The team didn't retain the paper records and so it may have missed the opportunity to analyse the records for any trends or patterns. The pharmacy used the digital system to record details of any dispensing incidents that had reached people. Details recorded included a description of the incident, factors that may have contributed to the incident and what actions the team had taken to prevent a similar incident happening again.

The pharmacy had a procedure to support the handling of complaints or feedback from people who used the pharmacy. The procedure was outlined via a notice displayed in the pharmacy's retail area. Team members normally received feedback verbally. Recently the pharmacy had received a complaint in relation to the pharmacy's ability to communicate messages within the team. The RP explained he agreed with the feedback and that team members needed to improve the way it relayed messages between each other. To improve, the team decided to start using a communications book to record messages for other team members to action.

The pharmacy had professional indemnity insurance. It was displaying the correct RP notice. The pharmacy held an RP record, but it was not being correctly completed as on several occasions, the RP on duty had not recorded the time their RP duties had ended. The pharmacy retained CD registers. The team mostly kept them in line with legal requirements but on some occasions register headers were not completed. The team completed balance checks of the CDs when a CD was dispensed to a person

and when the pharmacy received a delivery of new stock. The balance of three randomly selected CDs were checked and were correct.

The team held records containing personal identifiable information in areas of the pharmacy that only team members could access. The team separated confidential waste from general waste, and it was periodically destroyed using a shredder. Team members understood the importance of securing people's private information and they had completed training about General Data Protection Regulation (GDPR). The pharmacy had a written procedure to support the team in raising concerns about the welfare of vulnerable adults and children. Two team members, including the RP, had completed formal training on safeguarding vulnerable adults and children. Several team members described hypothetical situations that would raise a concern, and they were aware of the reporting procedure and the contact details of the local safeguarding teams.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy employs a team of qualified pharmacy team members to manage the workload. It provides some support to pharmacy team members to update their knowledge and skills. Team members work well together to help provide the pharmacy's services efficiently. And they can provide feedback and raise concerns where necessary.

Inspector's evidence

At the time of the inspection the RP was the pharmacy's resident pharmacist and SI. The RP worked at the pharmacy for three days a week. The RP was supported by a full-time qualified accuracy checking technician (ACT), two full-time qualified pharmacy assistants, a full-time qualified pharmacy technician and two part-time pharmacy assistants. Team members who were not present during the inspection included a delivery driver, a pharmacy undergraduate and the pharmacy's second pharmacist. The RP had been working at the pharmacy for over ten years and demonstrated a good rapport with many people who used the pharmacy. Part-time team members worked additional hours to cover other team members' planned and unplanned absences. The second pharmacist and several locum pharmacists worked the days the RP was absent. The pharmacy could request additional support from team members who worked at another local pharmacy owned by the company. Each team member explained they were comfortable in their roles, and they were observed working well together and supporting each other to manage the workload.

The pharmacy supported its team members to keep their knowledge and skills up to date. It did this by providing team members with some healthcare related modules to complete throughout the year. The RP generally decided which modules the team should complete and when. For example, in anticipation of summer, the team had completed some refresher training on how to manage the symptoms of hay fever. Team members received protected time to complete the modules. Team members were not able to select modules based on their own learning needs. The pharmacy didn't have a formal appraisal process. Team members generally held informal, ad-hoc conversations with the RP if they wished to discuss their own goals and development.

Team members attended informal team meetings where they said they could give feedback on ways the pharmacy could improve. But they were unable to provide any examples. Team members could raise concerns with either the RP or second pharmacist. Team members were not set any targets to achieve.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are suitable for the services the pharmacy provides to people. There is a suitable consultation room for people to use to have private conversations with team members.

Inspector's evidence

The pharmacy premises were clean, modern, hygienic, and generally well maintained. The dispensary was of a suitable size to manage the dispensing workload and there was ample space to store medicines. The benches used by team members to dispense medicines were kept organised throughout the inspection. There were several baskets containing medicines awaiting a final check stored on the floor of the dispensary. This created a risk of the baskets being knocked over and a trip hazard for team members. The risk was highlighted by the inspector and the RP gave assurances that they baskets would be removed following the inspection. The pharmacy had a suitable, private consultation room to support team members to have confidential conversations with people.

The pharmacy had separate sinks available for hand washing and for preparing medicines. There was a toilet, with a sink which provided hot and cold running water and other facilities for hand washing. Team members controlled unauthorised access to restricted areas of the pharmacy. Throughout the inspection, the temperature was comfortable. Lighting was generally bright throughout the premises, however the stairwell to the first floor was poorly lit and presented the risk of team members tripping.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides its services to people safely and effectively. It takes steps to ensure it actively promotes its services to its local community. The pharmacy correctly sources and stores its medicines. And it completes checks of its medicines to identify and highlight medicines which are close to expiring or out of date. But date-expired medicines aren't always removed from dispensing stock in a timely way. And this could increase the chance of the pharmacy supplying medicines to people which are not fit for purpose.

Inspector's evidence

There was a small step into the pharmacy from the street. To help people with pushchairs or wheelchairs access the pharmacy's services, team members served them at the entrance door. The pharmacy had a facility to provide large-print labels to people with a visual impairment. There were several leaflets providing information about the NHS hypertension case finding service. Team members provided people who could benefit from the service with a leaflet to take away with them. The pharmacy had also made bespoke leaflets in Urdu, as many people who used the pharmacy were elderly and preferred to converse in Urdu.

Team members had knowledge of the Pregnancy Prevention Programme for people in the at-risk group who were prescribed valproate, and of the associated risks. They knew to apply dispensing labels to valproate packs in a way that prevented any written warnings being covered up. And they always dispensed valproate in the original pack. The pharmacy supplied patient information leaflets and patient cards with every supply and had recently completed an audit of valproate patients to highlight any people the pharmacy supplied valproate to who may be at risk.

Team members used dispensing baskets to safely store medicines and prescriptions throughout the dispensing process. This helped manage the risk of medicines becoming mixed-up. Team members signed ‘dispensed by’ and ‘checked by’ boxes on dispensing labels to maintain an audit trail. The audit trail helped to identify which team member had dispensed the medicine and which team member had completed the final check. The ACT completed most of the accuracy checks. However, the RP didn’t record which prescriptions they had clinically checked. And so, this created a risk that some medicines were accuracy checked and then supplied to people without a clinical check of the prescription having taken place. This risk was discussed with the team. The RP provided assurances that following the inspection they would sign prescriptions to confirm a clinical check had been completed.

The pharmacy supplied some people with their medicines dispensed into multi-compartment compliance packs. These packs were designed to help people take their medicines at the right times. There were ‘master-sheets’ which team members used to cross-reference with prescriptions to make sure prescriptions were accurate before the dispensing process began. If they spotted a discrepancy, for example, if a medicine was missing from the prescription, they made enquires with the prescriber. Team members annotated the master sheets with details of authorised changes to people’s treatment. For example, if a treatment had been stopped. They recorded the details of the person who had authorised the change, for example, the person’s GP. People who received the packs were supplied with patient information leaflets and backing sheets. Each backing sheet was annotated with visual descriptions of each medicine to help them identify the contents. For example, pink, round, tablet. The

pharmacy kept records of the delivery service which they used to manage any queries.

The pharmacy stored pharmacy-only (P) medicines directly behind the pharmacy counter. The pharmacy had a process for the team to check the expiry dates of the pharmacy's medicines. But the team didn't keep records of when they completed this process. Five out-of-date medicines were found by the inspector following a check of approximately 30 randomly selected medicines. These medicines were marked with dot-stickers which mitigated the risk of them being supplied to people. The pharmacy had three fridges used to store medicines that required cold storage. And the team kept records of its minimum and maximum temperature ranges. A sample of the records was seen which showed two fridges were operating within the correct ranges. One fridge was operating at the correct current temperature, but its maximum temperature reading was slightly outside of the accepted range. The team gave assurances it would closely monitor the fridge. The team marked liquid medicines with details of their opening dates to ensure they remained safe and fit to supply. The pharmacy had medicine waste bags and bins, sharps bins and CD denaturing kits available to support the safe disposal of medicine waste. The pharmacy received medicine alerts through email. The team actioned the alert but didn't keep a record of the action it took. And so, an audit trail was not in place.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the correct equipment that it needs to provide its services. And it uses its equipment appropriately to help protect people's confidentiality.

Inspector's evidence

Team members had access to up-to-date reference sources including hard copies of the British National Formulary (BNF) and the BNF for children. The pharmacy used a range of measuring cylinders. There were separate cylinders to be used only for dispensing water. This helped reduce the risk of contamination. The pharmacy stored dispensed medicines in a way that prevented members of the public seeing people's confidential information. It suitably positioned computer screens to ensure people couldn’t see any confidential information. The computers were password protected to prevent any unauthorised access. The pharmacy had cordless phones, so that team members could have conversations with people in private. It had a blood pressure monitor which was scheduled to be replaced annually.

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.