General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Marisco Pharmacy, Marisco Medical Centre, Stanley Avenue, MABLETHORPE, Lincolnshire, LN12 1DP

Pharmacy reference: 1091892

Type of pharmacy: Community

Date of inspection: 25/01/2022

Pharmacy context

The pharmacy is co-located with a busy medical centre in the coastal town of Mablethorpe, Lincolnshire. It is open extended hours over seven days each week. The pharmacy serves both local residents and tourists during the busy holiday season. Its main services include dispensing NHS prescriptions and selling over-the-counter medicines. It delivers medicines to people's homes and provides a COVID-19 vaccination service from associated premises around 14 miles from the pharmacy. The inspection took place during the COVID-19 pandemic.

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 appropriately. It keeps people's private information secure and it keeps the records it must by law. The pharmacy advertises how people can provide feedback about its services. And its team members understand their role in responding properly to this feedback. They know how to correctly recognise and respond to safeguarding concerns. Pharmacy team members engage in some learning to help reduce risk following mistakes they make during the dispensing process.

Inspector's evidence

The pharmacy had addressed risks associated with providing pharmacy services during the pandemic. There was a good quality plastic screen fitted across the length of the medicine counter. This helped to maintain social distancing and reduced the risk of spreading the virus. Notices in window displays informed people of the need to wear a face covering when visiting the pharmacy. And they advised on a cap in the number of people allowed in the public area at any given time. An internal entrance between the pharmacy and medical centre remained closed throughout the pandemic. This helped to manage the flow of people through the pharmacy during busier periods. Team members had appropriate access to personal protective equipment (PPE) and most team members wore type IIR face masks whilst working.

The pharmacy had up-to-date standard operating procedures (SOPs) in place to support the safe running of the pharmacy. It stored these electronically and they covered responsible pharmacist (RP) requirements, controlled drug (CD) management, dispensary processes and pharmacy services. The next review date was identified as January 2023. But individual SOPs did not identify who had carried out the last SOP review, and who was responsible for undertaking the next. The pharmacy manager confirmed a senior pharmacist within the company had this responsibility. The pharmacy held training records associated with the SOPs manually. There was a need for some newer team members to complete learning associated with the SOPs. Trainee team members on duty during the inspection discussed their roles and responsibilities. They understood the need to refer to the pharmacist or another colleague for support. And all team members were observed working together well and prioritising tasks. Pharmacists completed the majority of checking tasks. But during busy periods an accuracy checking technician (ACT) carried out some final accuracy checks. In these circumstances the RP recorded the clinical check of these prescriptions on the prescription form ahead of the final accuracy check taking place. The RP was aware of his responsibilities associated with the COVID-19 vaccination site. And understood the governance framework that supported this service. Communication between a site lead and the RP generally took place through a secure messaging application. And the RP reflected on how he had been kept fully informed when a person had had an acute adverse reaction to a vaccine.

Pharmacy team members were working to improve near miss reporting processes. There were some gaps in reporting throughout the pandemic. But recent records included details of the mistake made alongside action points and learning outcomes. Team members discussed their mistakes as part of their learning process. But the pharmacy had not established a regular review process to help identify trends in mistakes. This meant that there was some missed opportunities to share learning and to measure the

effectiveness of any action taken to reduce risk. The pharmacy reported dispensing incidents through an electronic system. Records contained details of the event but did not routinely include any action the team had taken in response to an incident. The RP provided some examples of how the reporting process led to a review of current risk. And there was evidence of action being taken to reduce the risk of similar mistakes occurring. For example, furosemide and gliclazide strengths had been separated on the dispensary shelves following an incident. And the team had changed the process for how it managed split boxes during the dispensing process following another incident.

The pharmacy had up-to-date indemnity insurance arrangements in place. The RP notice displayed the correct details of the RP on duty. And other pharmacy records examined were generally made in accordance with legal and regulatory requirements with some minor omissions noted. These omissions did not impact on patient safety. The pharmacy held personal identifiable information in staff only areas of the pharmacy and on password protected computers. It had appropriate arrangements in place for managing confidential waste.

The pharmacy had a complaints procedure in place. And it advertised details of how members of the public could provide feedback or raise a concern. A team member explained how they would handle a concern and understood when to refer to the pharmacist or manager for support. Team members had access to SOPs associated with safeguarding vulnerable adults and children. Some safeguarding learning was included within accredited training courses. But most team members had not completed any further learning on the subject. Pharmacy professionals had completed level two safeguarding training through the Centre for Pharmacy Postgraduate Education (CPPE). A team member clearly explained how they would identify and report a safeguarding concern to the manager or pharmacist in the first instance. And the team had access to contact information for safeguarding teams.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough team members to manage its workload. It has some support systems to help team members in learning roles. But it does not provide protected learning time to help monitor completion of core learning associated with the pharmacy's procedures. Team members have the confidence to talk about concerns at work. And they engage in some ongoing discussions to share ideas and learning.

Inspector's evidence

One full-time pharmacist worked at the pharmacy alongside regular locums and company-employed pharmacists. But on occasions throughout the pandemic the team discussed having to close due to being unable to obtain pharmacist cover at short notice. There was a process in place for notifying NHS England of closures. And the manager discussed the pharmacy's business contingency arrangements for managing an acute closure. The pharmacy had experienced some staffing changes throughout the pandemic. The current team included the regular pharmacist, the pharmacy manager (an ACT), an assistant manager (pre-registration pharmacy technician), four qualified dispensers, three trainee dispensers and four part-time delivery drivers.

Trainee team members were in the process of working through their induction period prior to being enrolled on accredited training courses associated with their roles. The pharmacy did not provide protected learning time for its team members. But some time was available during quieter periods. Learning focussed on SOPs and essential learning required to meet the requirements for the NHS Pharmacy Quality Scheme (PQS). The pharmacy did not have a structured appraisal process to help review the ongoing development needs of its team members. But one team member who had completed dispenser training at the pharmacy described a supportive approach to their learning and development. For example, both the RP and manager had provided support throughout the training course. And the team member had identified and discussed a career progression opportunity with the superintendent pharmacist (SI). Another team member had been supported in a short-term change to their role to support their personal needs.

The pharmacy did not have specific targets in place for its services. The RP expressed feeling able to apply his professional judgement when undertaking services which he identified may be of benefit to a person. Pharmacy team members were confident when explaining how they could provide feedback or share ideas at work. And they had some awareness of how to escalate a concern at work. But not all team members were familiar with the pharmacy's whistleblowing policy. The team shared information informally through discussion. But it did not take the opportunity to record the outcomes of these talks. This meant that the opportunity to share learning and measure the impact of any agreed actions within these informal meetings was limited.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are clean and secure. They provide a suitable space for the delivery of healthcare services. People using the pharmacy can speak with a member of the pharmacy team in a private consultation room.

Inspector's evidence

The pharmacy had benefitted from a small refit since the last inspection. This had improved the use of space in the dispensary. And it had dramatically improved storage arrangements for holding bags of assembled medicines. The pharmacy was appropriately clean and secure. It consisted of an open plan public area, a consultation room, storerooms and the dispensary. A low-level gate divided the medicine counter from the public area, and provided access through to the dispensary. The dispensary was small for the volume of items dispensed. But the extended opening hours helped to manage this. And team members managed the space available to them well.

Lighting was bright and ventilation was appropriate with air conditioning used to maintain an ambient temperature suitable for the storage of medicines. The pharmacy's only sink was in its consultation room. This was used for the reconstitution of liquid medicines and for handwashing. Staff accessed bathroom facilities within the medical centre. The pharmacy's consultation room was small but it was accessible to people visiting the pharmacy.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy makes its services accessible to people. It obtains its medicines from reputable sources. And it generally stores these medicines safely and securely. Pharmacy team members use audit trails effectively to help manage dispensing services. And team members work with other healthcare providers to supply information to people to support them in managing their health.

Inspector's evidence

The pharmacy was accessed through a push/pull door leading from the medical centre carpark. Pharmacy team members were aware of how to signpost people to another pharmacy or healthcare provider if they were unable to supply a medicine or provide a service. The pharmacy team described a good working relationship with the medical centre. And team members were able to contact prescribers and medical centre staff to query prescriptions with relative ease. This helped to reduce waiting times for people, and supported smooth workload management.

The pharmacy protected Pharmacy (P) medicines from self-selection as it displayed them behind the medicine counter. And the RP had adequate supervision of activity taking place within the public area of the pharmacy. The RP was observed speaking to people and counselling them on the use of their medicines when required. The pharmacy team was aware of the requirements of providing additional information when dispensing valproate. Team members spoken to could not recall seeing a prescription for a person in the high-risk group. A discussion took place about the need to verbally counsel and make the necessary assurance checks associated with the valproate pregnancy prevention programme, if a person within the high-risk group presented with a prescription for valproate. The pharmacy had some processes in place for identifying higher risk medicines. Cold chain medicines and most CDs were supplied in clear bags to prompt additional checks during the dispensing and handout process. And the RP had direct supervision over medicines requiring safe custody. The pharmacy worked together with local monitoring teams to pass on key information about the importance of regular monitoring checks associated with medicines such as warfarin. But pharmacy team members did not record this information on people’s medication records.

The pharmacy used coloured baskets throughout the dispensing process. This kept medicines with the correct prescription form and informed workload priority. The pharmacy team kept original prescriptions for medicines owing to people. It used the prescription throughout the dispensing process when the medicine was later supplied. Audit trails to support the medicine delivery service were effectively maintained. People were not required to sign for receipt of their medicines through the delivery service due to the ongoing pandemic. The pharmacy used audit trails and provided evidence of clinical checks associated with prescriptions sent to the company’s hub pharmacy. The company hub assembled the majority of multi-compartment compliance packs. A team member acted as a liaison between the hub and surgeries. The RP described a risk assessment process which would occasionally see the pharmacy take over management of a person’s multi-compartment compliance pack. For example, when a person was experiencing frequent changes in their medicine regimen.

The pharmacy sourced medicines from licensed wholesalers and specials manufacturers. It stored medicines in an orderly manner, and generally within their original packaging, on shelves throughout the dispensary. A small number of medicines were stored loose in blisters which could potentially

increase the risk of a mistake being made during the dispensing process. Pharmacy team members described following regular date checking processes and they checked expiry dates during the dispensing process. But the team did not use a date checking matrix to support them in the completion of these tasks. This meant it was more difficult to monitor date checking activity during busier periods. For example, peak tourist season. A random check of dispensary stock found no out-of-date medicines. And most short-dated medicines were highlighted. The team generally annotated details of opening dates on bottles of liquid medicines. This helped to identify if the medicine remained safe and fit to supply.

The pharmacy held CDs in secure cabinets. Medicines storage inside the cabinets was orderly. The pharmacy's medical fridges were full to capacity but stock was generally held in an orderly manner within the fridges. One fridge did not have an appropriate number of shelves to support the stock it held. The pharmacy held medicines in stacked baskets within this fridge. But the absence of the shelves potentially increased the risk of inadequate airflow between products. The manager confirmed the issue could be rectified with ease by obtaining additional shelving to support the safe storage of these medicines. And a follow-up conversation with the SI after the inspection confirmed plans to improve the storage arrangements within this fridge. The pharmacy maintained a fridge temperature record which showed fridges were operating within the accepted temperature range of two and eight degrees Celsius. But there were some gaps in recording noted. The pharmacy had appropriate medical waste bins and CD denaturing kits available. It received medicine alerts through email and there was an appropriate process in place for checking these alerts against stock held by the pharmacy.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs to provide its services. Pharmacy team members act with care by using the equipment in a way which protects people's confidentiality.

Inspector's evidence

The pharmacy had up-to-date written and electronic reference resources available including the British National Formulary (BNF) and BNF for children. Pharmacy team members could access the internet to help resolve queries and to obtain up-to-date information. Computers were password protected, and positioned so information on computer monitors was not visible from the public area. The pharmacy stored bags of assembled medicines in a protected area. This meant details on bag labels were not seen from the public area of the pharmacy. Members of the pharmacy team used cordless telephone handsets. This meant they could move out of earshot of the public area if the phone call required privacy.

The pharmacy had a range of clean equipment available to support the delivery of its services. Equipment included counting apparatus for tablets and capsules, and appropriate measuring cylinders for measuring liquid medicines. The pharmacy held some equipment to support its services within its consultation room. For example, consumables and anaphylaxis supplies for the flu vaccination service. And it was in the process of procuring and making equipment available to support the launch of the NHS hypertension case findings service.

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.