General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Pharmacy Wise Barton Upon Humber, 1 High Street, BARTON-UPON-HUMBER, South Humberside, DN18 5PA

Pharmacy reference: 1092885

Type of pharmacy: Community

Date of inspection: 08/07/2024

Pharmacy context

This community pharmacy is on the high street in the town of Barton-Upon-Humber, North Lincolnshire. Its main services include dispensing prescriptions and selling over-the-counter medicines. The pharmacy provides a range of NHS consultation services including the NHS New Medicine Service (NMS), NHS blood pressure check service and NHS Pharmacy First service. It supplies some medicines in multi-compartment compliance packs, designed to help people remember to take their medicines. And it delivers some medicines 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 appropriately identifies and manages the risks for providing its services. Overall, it keeps its records as required by law. And it keeps people's confidential information secure. Its team members work well within their roles, and they act openly and honestly by recording and discussing their mistakes. They understand how to manage feedback and concerns they may receive about the pharmacy. And they have the skills and knowledge to recognise, and report concerns to help keep vulnerable people safe.

Inspector's evidence

The pharmacy had changed ownership in August 2023. Its current owners had implemented its own standard operating procedures (SOPs) to support the safe and effective running of the pharmacy. The most recent version of SOPs was implemented in April 2024 and contained details of a two-year review date. Pharmacy team members had access to digital versions of the SOPs on a shared drive and were familiar with them. But most team members had not completed training records to confirm they had read and understood them. The pharmacy manager was aware of this and demonstrated how the team had recently started completing these training records. A younger person had recently completed a placement at the pharmacy through a local work experience scheme. The pharmacy had addressed the risks of supporting the placement through a formal risk assessment. And it had taken appropriate steps to ensure the temporary team member completed appropriate learning of key areas of risk including health and safety, and confidentiality. Team members were observed completing tasks safely and effectively throughout the inspection. They understood that they could not carry out operational activities, including the sale of general sales list (GSL) medicines should a responsible pharmacist (RP) not be signed in. And a team member discussed the tasks they could not complete if the RP took absence from the pharmacy.

The pharmacy had processes for managing mistakes its team members made and identified during the dispensing process, known as near misses. Following a mistake, team members were normally asked to check their work and correct their own mistake. They generally recorded their near misses along with the actions they took to correct the mistake. But they did not formally review the near miss record to identify trends in these types of mistakes. And they did not routinely record any actions they took to reduce the risk of similar mistakes occurring. Team members provided examples of how they acted to reduce risk such as separating medicines with similar names and packaging within the dispensary drawers. The RP on duty discussed how they shared wider safety information with the team to inform practice. For example, they had shared a recent case study issued by the NHS controlled drug (CD) accountable officer. The pharmacy had an incident reporting procedure in the event a mistake was identified following the supply of a medicine to a person, known as a dispensing incident. Evidence of incident reporting was available. And investigation notes identified the contributing factors leading to the mistake and the actions taken by the team to reduce the risk of a similar mistake occurring.

The pharmacy had a complaints procedure and team members understood how to manage feedback and respond to concerns. They knew how to escalate concerns to the attention of the manager, RP, or pharmacy's superintendent pharmacist (SI). The pharmacy had procedures to support team members in identifying and reporting safeguarding concerns. And the team members on duty had completed

learning to assist them in recognising and reporting these concerns. They provided examples of concerns they had shared with GP surgeries and with people's key workers. The pharmacy advertised its consultation room as a safe space. But not all team members were fully aware of how to recognise and manage a request from a person wishing to access this safe space. They explained they would seek support from the manager or RP should they be unsure of a person's needs.

The pharmacy held all personal identifiable information on password-protected computers and on paper records within the staff-only areas of the pharmacy. Pharmacy team members followed secure processes when segregating and disposing of confidential waste. The pharmacy had current indemnity insurance arrangements. The RP notice was updated as the inspection process began to reflect the correct details of the RP on duty. The RP record was generally completed in full. This was checked frequently and notes were made against entries to address any gaps found in the register. The pharmacy maintained appropriate records when supplying unlicensed medicines. A sample of records made in the private prescription register found team members did not always enter the prescriber's details accurately when entering the supply of a medicine against a private prescription. The pharmacy kept its CD register as legally required. It maintained running balances in the register, and it completed frequent checks of physical stock against these balances. Random physical balance checks of CDs completed during the inspection matched the balance recorded in the CD register. The pharmacy kept a record of patient-returned CDs, and it updated this record upon receipt of a return.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy employs a team of people with the right knowledge and skills to provide its services. Team members work together well, and they engage in ongoing learning relevant to their role. They take some opportunities to share learning with each other. And they are confident in providing feedback at work.

Inspector's evidence

The RP was a regular locum pharmacist working three days a week at the pharmacy. Other locum pharmacists provided cover across the remaining three days. Most of the pharmacists worked at the pharmacy regularly. Two qualified dispensers, one of which was the pharmacy manager, and a delivery driver were working alongside the RP. A team member who was qualified as a pharmacist in a European Economic Area (EEA) country was also on duty. They had worked at the pharmacy for approximately a month undertaking learning ahead of applying to the GPhC to have their EEA qualification recognised. They discussed some of the steps they were taking to support them with their learning which included reviewing their clinical knowledge and preparation to support them in providing evidence for the English language requirements for registration. The pharmacy also employed another three qualified dispensers, one dispenser was on long term planned leave. Team members had recently adjusted their hours as part of a staffing level and skill mix review. The manager felt there was current flexibility within the team to support for both planned and unplanned absence from work. And they understood the need to raise any concerns about staffing levels directly with the SI. The pharmacy team was up to date with its workload and team members were observed working well together to manage workload and prioritise tasks. The pharmacy had some targets associated with the delivery of NHS services. The RP discussed their approach to providing consultation services and felt able to apply their professional judgement when working at the pharmacy.

Pharmacy team members engaged in ongoing learning relevant to their roles and to support them in delivering the pharmacy's services safely. For example, they had completed supervised learning ahead of supporting the delivery of the NHS blood pressure check service. But they had not yet had an opportunity to engage in appraisals at work to support their learning and development needs. Pharmacy team members felt confident in providing feedback at work and provided examples of how their ideas were listened to. For example, one team member had suggested ways of highlighting people's eligibility for some services and the pharmacy had implemented this idea. The pharmacy had a whistle blowing policy and team members knew how to report and escalate concerns at work. Team members shared non-sensitive information and learning through a secure messaging application between shifts.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean, secure, and suitably maintained. It provides a professional environment for the delivery of healthcare services. Its consultation facilities allow people to have a private conversation with a member of the pharmacy team.

Inspector's evidence

The pharmacy was secure, well maintained, and clean. The team reported maintenance concerns to the pharmacy's head office, and they were provided with approval to use local tradespeople to resolve any maintenance issues that occurred. The pharmacy was generally tidy, there was some old retail display units waiting for disposal that had belonged to the previous owners. These were stored in a staff-only area of the premises and did limit storage space for the items such as dispensary sundries. The pharmacy had air conditioning and lighting throughout the premises was bright. Pharmacy team members had access to toilet facilities and sinks equipped with antibacterial hand wash and paper towels. A sink in the dispensary was used for reconstituting liquid medicines and washing equipment used in the preparation of medicines.

The public area was fitted with wide spaced aisles and a private consultation room was accessible to the side of this area. The consultation room offered a suitable professional space for providing consultation services. To the side of the public area was a staff-only area. This area included space to store excess retail stock and dispensary sundries. A staff kitchen and toilet facilities were also accessible in this area of the pharmacy. Access into the dispensary was suitably restricted to team members only through the layout of the premises. The dispensary provided appropriate space for managing current levels of activity and the team used the workspace effectively. For example, they used a workbench at the far-end of the dispensary when assembling medicines in multi-compartment compliance packs. This suitably reduced the risk of distraction during the dispensing process.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's services are readily accessible to people. It obtains its medicines from licensed sources. And it stores these medicines safely and securely. The pharmacy team follow written processes to support them in providing services effectively. They make regular checks to ensure medicines are safe to supply to people. And they take regular opportunities to speak to people and provide them with information to support them in taking their medicines safely.

Inspector's evidence

People accessed the pharmacy through a power-assisted door up a small step from street level. A portable ramp was available for people to use. The pharmacy advertised its opening times and information about its services. It had a bright display in its public area providing helpful information such as leaflets produced by The British Heart Foundation to support people in living healthy lifestyles. Pharmacy team members knew to signpost people to other pharmacies or healthcare services if they required a service or medicine the pharmacy could not provide.

Team members had access to appropriate information to support them in delivering the pharmacy's services safely. For example, patient group directions, clinical pathways, and service specifications for the Pharmacy First service. A team member was observed reporting the results of blood pressure checks and pulse checks to the RP for appropriate clinical intervention as part of the pharmacy's approach to delivering the NHS blood pressure check service.

The RP provided examples of positive outcomes for people accessing its consultation services including people who had been started on treatment for high blood pressure and irregular heart rate. This had provided further opportunities for the pharmacy to support people taking new medicines through the NHS New Medicine Service.

The pharmacy displayed Pharmacy (P) medicines from self-selection behind plastic screens within the public area. Notices on the screens advised people to seek staff assistance if they required a medicine from these areas. And people were observed doing this. A team member explained a prompt on the pharmacy till alerted team members if a P medicine was brought to the counter by a person without staff assistance. This helped team members to make relevant checks to ensure the sale was appropriate and to provide relevant information to people to support them in taking the medicine safely. The team was particularly keen on monitoring requests for higher-risk P medicines liable to abuse. They shared information about repeat requests with each other to ensure appropriate intervention and referral to the pharmacist. And they provided examples of where they had refused inappropriate requests and had signposted people to their own GP.

The pharmacy team had processes to support it in dispensing higher-risk medicines safely. It effectively monitored the supply of medicines to people on opioid treatment programmes to support it in supplying these medicines safely. And it communicated concerns with prescribers and people's key workers when needed. Pharmacists had access to a good range of support materials to support ongoing checks and counselling when supplying some higher-risk medicines requiring ongoing monitoring. The RP discussed the counselling they would provide to people when handing out these medicines and recorded these types of interventions on people's patient medication record (PMR). The pharmacy

team had recently received information to support them in complying with the requirements of the topiramate and alitretinoin Pregnancy Prevention Programmes (PPPs). The RP discussed the requirements of the valproate PPP. And the team was aware of the need to supply valproate in the manufacturer's original container.

The pharmacy used baskets throughout the dispensing process. This kept medicines with the correct prescription form. Pharmacy team members signed their initials in the 'dispensed by' and 'checked by' boxes on medicine labels. This provided a dispensing audit trail and helped to direct a query should one arise. The pharmacy kept a record of the medicines it owed to people, and team members used the original prescription when dispensing owed medicines. It kept an audit trail of the medicine deliveries it made to people's homes. People were required to sign personalised delivery sheets when accepting receipt of a CD. The team used the PMR system and compliance pack records to support it in supplying medicines in multi-compartment compliance packs. Team members checked changes to medicine regimens with GP surgery teams and amended the person's compliance pack record to reflect the change. But they did not routinely record details of the checks they made with the GP surgery team when amending the record to support them in answering any queries that may arise. A sample of compliance packs found clear descriptions and dispensing audit trails on the attached backing sheets. And the pharmacy routinely provided patient information leaflets at the beginning of every four-week cycle of compliance packs.

The team sent some of its workload to the company's offsite dispensing hub pharmacy. Team members received appropriate training to help them identify which prescriptions were not suitable for sending to the hub. For example, prescriptions for medicines required immediately such as antibiotics. The PMR also flagged medicines which required local dispensing such as those in split packs and controlled drugs. The pharmacy's processes for this service ensured a pharmacist completed data accuracy checks and clinical checks of prescriptions prior to transmitting data to the hub pharmacy. Some prescriptions were part-dispensed locally and part-dispensed by the hub pharmacy. A team member demonstrated how this was clearly identified on the PMR. And team members were able to pull a prescription back for local dispensing if there was a need to do this. The team placed returned bags of assembled medicines inside bags containing locally dispensed medicines if part of the supply was made by the hub pharmacy and part of the supply was made locally. This helped to ensure people were provided with all of their medication when collecting it.

The pharmacy sourced medicines from licensed wholesalers and specials manufacturers. It stored medicines in an orderly manner within their original packaging. It held its CDs in an orderly manner within secure cabinets. Patient-returned CDs and out-of-date CDs were clearly labelled and held separately to stock medicines. And assembled CDs were easily identifiable. The pharmacy held medicines requiring cold storage in a suitable medical fridge. It kept temperature records for the fridge. A sample of these records showed the fridge had remained within the required range of two and eight degrees Celsius. Pharmacy team members made regular checks of stock medicines to ensure they were safe to supply to people. They kept records of these checks and of any medicines identified as having short expiry dates. They annotated bottles of liquid medicines when opening them with details of the date they were opened to support them in ensuring the medicine remained safe to supply to people. The pharmacy had appropriate medicine waste receptacles and CD denaturing kits available. It actively encouraged people to return unwanted medicines and used inhalers for safe disposal. It received medicine alerts through email and there was evidence these alerts were read. But the pharmacy did not record the specific checks or actions it made in response to the alerts. A discussion shared information about common approaches used by pharmacies to support the team in doing this.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has appropriate equipment and facilities for providing its services. It makes checks to ensure equipment is in safe working order. And its team members use the equipment in a way which maintains people's confidentiality.

Inspector's evidence

Pharmacy team members had access to the internet and digital reference resources to support them in obtaining information. They used passwords and NHS smart cards when accessing people's medication records. The pharmacy protected information on computer monitors from unauthorised view through the layout of the premises. It stored bags of assembled medicines out of direct view of the public area. This arrangement suitably protected any confidential information on bag labels and prescription forms from unauthorised view.

The pharmacy team used a range of clean and appropriate equipment to support it in delivering the pharmacy's services. For example, standardised measuring cylinders for measuring liquid medicines and counting triangles for counting tablets. It clearly identified separate equipment for measuring and counting higher-risk medicines to avoid any risk of cross contamination. The pharmacy held the equipment required to provide its consultation services neatly within its consultation room. Equipment was from recognised manufacturers, and it was clean and ready to use. Information about ongoing monitoring checks required for the equipment used to support the NHS Pharmacy First service was documented. Electrical leads belonging to the pharmacy's electrical appliances were annotated with details of the last safety check conducted in June 2023.

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.