General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Amber Pharmacy, Four Lane Ends, Horsley Woodhouse, ILKESTON, Derbyshire, DE7 6AX

Pharmacy reference: 1092960

Type of pharmacy: Community

Date of inspection: 23/03/2023

Pharmacy context

This busy community pharmacy is located next to a medical centre in the centre of the village. Most people who use the pharmacy are from the local area and a home delivery service is available. The pharmacy dispenses NHS prescriptions, and it sells a range of over-the-counter medicines. It supplies some medicines in multi-compartment compliance aid packs to help people take their medicines at the right time. The pharmacy carried out covid-19 vaccinations during the pandemic from an associated premises.

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	Good practice	1.1	Good practice	The pharmacy team records and analyses adverse dispensing incidents to identify learning points which it incorporates into day-to-day practice to help manage future risks.
		1.2	Good practice	The pharmacy completes regular checks and audits to make sure it is operating safely and help improve the quality of services.
2. Staff	Good practice	2.2	Good practice	The team members have the appropriate skills, qualifications and competence for their roles. And the pharmacy proactively supports them to address their ongoing learning and development needs.
		2.3	Excellent practice	Pharmacy professionals and other members of the pharmacy team are empowered through effective delegation and collaboration for the benefit of their patients and the wider public.
		2.4	Good practice	The pharmacy team members are enthusiastic about their roles. They work well together to acheive common goals. Team members communicate effectively, and openness, honesty and learning are encouraged.
3. Premises	Standards met	N/A	N/A	N/A
4. Services, including medicines management	Good practice	4.1	Excellent practice	The pharmacy offers a wide range of services which are effectively tailored to the local community and are easy for people to access. The pharmacy team works closely with other healthcare professionals, and it actively promotes people's health and wellbeing, delivering services in innovative ways.
		4.2	Good practice	The pharmacy proactively manages its services to ensure effective care and improved outcomes for local people.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance ✔ Good practice

Summary findings

The pharmacy proactively manages the risks associated with its services to ensure it keeps people safe. It completes risk assessments and regular audits to make sure it operates safely and to help improve the quality of its services. It asks its customers for their views and completes all the records that it needs to by law. Members of the pharmacy team work to professional standards, and they are clear about their roles and responsibilities. The pharmacy has effective systems to record their mistakes so that they can learn from them, and they act to help stop the same sort of mistakes from happening again. The team members keep people's private information safe. And they complete training, so they know how to protect children and vulnerable adults.

Inspector's evidence

The pharmacy had up-to-date standard operating procedures (SOPs) for the services it provided. These were accessible to pharmacy team members through an electronic portal. Each member of the team could sign onto the portal and view the SOPs relevant to their role. There was a record of the date they had read and accepted the SOPs. The pharmacist superintendent (SI) and the company's professional regulation pharmacist had oversight of this and could see if any members of the team had outstanding training to complete on the SOPs. Locum pharmacists had access to the SOPs and were required to read them before working in the pharmacy. This was checked along with their indemnity insurance on a regular basis. Roles and responsibilities were set out in the SOPs and the pharmacy team members were performing duties which were in line with their roles. They were wearing uniforms and name badges showing their roles. The name of the responsible pharmacist (RP) was displayed as required by the RP regulations.

A business continuity plan was in place which gave guidance and emergency contact numbers to use in the case of systems failures and disruption to services. The pharmacy team recorded dispensing incidents and near misses electronically, and action taken to prevent a similar occurrence and learning points were included and discussed at monthly huddles. For example, following an incident when the incorrect form of insulin was given the team were reminded about the different forms available and to always double check insulins. One member of the pharmacy team was responsible for reviewing errors and near misses. The SI and professional regulation pharmacist had oversight of this activity and helped to share learning with other pharmacies in the company. Minutes were available from previous team huddles. One section was on key safety news from across the business and included dispensing incidents, near misses and drug alerts. Clear plastic bags were used for assembled controlled drugs (CDs) to allow an additional check at hand out. Pharmacy team members had completed training on look-alike and sound-alike drugs (LASAs) so extra care was taken when dispensing and checking these. 'High risk item' alert labels were placed in front of steroids, lithium, blood thinners and valproate and a dispenser explained the team were focusing on these medicines as extra counselling and checks were required. New Services were assessed before commencing. For example, the covid vaccination service had been risk assessed to ensure the associated premises was suitable and the required equipment was in place.

There was a regulatory checklist on display showing daily, weekly, and monthly checks that were taking place. A monthly regulatory audit was carried out by the professional regulation pharmacist. This

included checks on SOPs, patient safety, record keeping, medicine storage, drug alerts, date checking, cleaning and health and safety. Any required actions were documented and discussed at the monthly huddles. For example, the team were reminded to always ensure that all signposting was recorded on the signposting log on the medicines counter. And all interventions were recorded, and the action taken in response to safety alerts and drug recalls was always recorded. Progress made on the actions from the previous month was discussed as the start of each huddle. For example, team members were thanked for completing the required training which had been allocated to them, and team members were alerted to outstanding SOPs which they were required to read and sign. Clinical audits were completed regularly. The most recent ones included audits on antibiotics, valproate, and the New Medicine Service (NMS).

A member of the team described how they would deal with a customer complaint, and how they would attempt to resolve the situation themselves but involve the pharmacist or SI if required. They pointed out a notice which was on display in the waiting area of the pharmacy with the pharmacy's complaint procedure and the details of who to complain to. These details were also included on a notice behind the counter for the benefit of the pharmacy team. Any complaints were discussed at the monthly huddle so all team members could learn from them.

Appropriate insurance arrangements were in place. A current certificate of professional indemnity insurance was on display in the pharmacy. Private prescription records, the RP record, and the CD registers were in electronic format and appeared to be appropriately maintained. Records of CD running balances were kept and these were regularly audited. Two CD balances were checked and found to be correct. Team members were aware what percentage of discrepancy in the running balance of methadone solution could be attributed to manufacturer's overage, and what percentage would trigger an investigation. Patient returned CDs were generally recorded and disposed of appropriately, although some examples were seen when disposals had not been recorded properly. The SI said he would investigate this and ensure the destructions were properly recorded each time. Following the inspection the SI confirmed that these records had now been completed.

All members of the pharmacy team had completed training on information governance (IG) and data protection which included details about confidentiality. Confidential waste was placed in designated bins until it was collected by a waste disposal company for destruction. The accuracy checking technician (ACT) correctly described the difference between confidential and general waste. Assembled prescriptions and paperwork containing patient confidential information were stored appropriately so that people’s details could not be seen by members of the public. A privacy statement was on display, in line with the General Data Protection Regulation (GDPR). IG was audited as part of the monthly regulatory audit.

The pharmacists and pharmacy technicians (PTs) had completed level three training on safeguarding. Other staff had completed level one or two depending on their role. There was a safeguarding notice on display containing the contact numbers of who to report concerns to in the local area. The pharmacy had a chaperone policy. This was highlighted to people on a notice inside the consultation room. But there was nothing on display outside the room, so people might not realise that this was an option. All members of the pharmacy team were working through training to become ‘Dementia Friends,’ in order to have a better understanding of people living with this condition. All members of the team had completed training on the ‘Safe Space’ initiative, where pharmacies were providing a safe space for victims of domestic abuse. And the pharmacy had completed the documentation to be registered for this.

Principle 2 - Staffing ✔ Good practice

Summary findings

The pharmacy’s team members work effectively together to manage the workload. The pharmacy team shares ideas and learning both inside and outside of the organisation to benefit other healthcare professionals and the wider public. Team members are well trained, and the pharmacy supports and encourages them to keep their skills up to date and supports their development. They are enthusiastic and knowledgeable about their roles. And the pharmacy enables them to act on their own initiative and use their professional judgement to benefit people who use the pharmacy’s services. Team members are comfortable providing feedback to their manager and they receive feedback about their own performance.

Inspector's evidence

The SI was working as the RP. There was an ACT, a pharmacy technician (PT), four NVQ2 qualified dispensers (or equivalent), a trainee medicine counter assistant (MCA) and an apprentice pharmacy assistant on duty at the time of the inspection. There were also three delivery drivers on the pharmacy team. The staffing level was adequate for the volume of work during the inspection and the team were observed working collaboratively with each other and people who visited the pharmacy. There was a team rota on display in the staff room which showed the team members names, their role, and their planned hours for that week. Holiday request forms were used to help organise planned absences which were covered by re-arranging the staff rota or transferring staff from a neighbouring branch if necessary. Some of the team members were part time so there was flexibility in their hours to provide extra cover. The SI explained that they ensured that the rota always had a minimum of four dispensers and two MCAs on duty.

Members of the pharmacy team carrying out the services had completed appropriate training and appeared, competent, confident and enthusiastic in their roles. Team members were given a ‘happy hour’ each week when they could complete activities, away from the dispensary such as administration, filing or training. All members of the team were given specific areas of additional responsibility. This helped them develop leadership, communication, and organisational skills. One member of the team had been delegated to be responsible for training and she liaised with the professional regulation pharmacist to ensure the team’s training was up to date. Team members all had protected training time. They had access to various training resources and kept records of their completed training on an e-learning platform. Some qualification certificates were on display in the pharmacy. One member of staff demonstrated that she had recently completed training on cancer, melanomas and other skin cancers, referral of red flag symptoms, dementia, data protections and health and safety. The apprentice had half a day of training time each week and had regular contact with a tutor from a local college. He had completed the first part of his apprenticeship which allowed him to work as an MCA , and he had started the dispensing part of the course so he could carry out some dispensing activities such as labelling. One dispenser had nearly completed an NVQ3 course. She was the dispensary manager, and she was about to start a management training course.

The pharmacy was one of the first pharmacies in the UK to offer the Covid-19 vaccination service. The team members had helped other pharmacies hoping to set up a vaccination service by sharing best practices and their patient centred approach. During the vaccination programme, the pharmacy worked

with a multi-disciplinary team which included retired doctors, nurses, pharmacists and the army. The pharmacy had many visitors at the time who endorsed the work done by pharmacists in the community and the SI was interviewed on the BBC local radio, BBC News, and ITV to showcase the work done during the pandemic. The SI sat on the weekly Covid-19 vaccination briefings to commissioners. He had also presented on the introduction of a hypertension service at the vaccination site which highlighted the opportunity which pharmacy professionals have to promote health and wellbeing when they come into contact with people, other than simply vaccinating them. The concept was shared at an NHS Futures meeting and was adopted for all vaccinations sites under the umbrella of "Making Every Contact Count". The SI's write up of the study was available on the NHS Futures website which was available for all NHS commissioners in England.

The SI was a member of the LPC and was the pharmacists primary Care network (PCN) lead. This enabled him to share learnings from his practice. He was also part of the medicines management team for the PCN surgeries. He attended the medicine management meeting at the medical centre next door where issues such as managed repeat patients, emergency supplies and the discharge service referrals were discussed, so the teams were working together to improve patient outcomes.

The pharmacy team were given formal appraisals where performance and development were discussed and received 'in the moment' feedback informally from the SI, and dispensary manager. As well as the formal monthly huddle, other issues were discussed within the team as they arose. A dispenser confirmed there was an open and honest culture in the pharmacy and said she would feel comfortable talking to the SI about any concerns she might have. She said she was comfortable admitting and reporting errors and felt that learning from mistakes was the focus.

The SI empowered team members to exercise their professional judgement and allowed them to comply with their own professional and legal obligations, and he supported the team members. For example, when a pharmacist refused to sell a pharmacy medicine containing codeine to a person who was also receiving it on prescription, the person became abusive towards the pharmacist. The SI sat down with the person and explained that their behaviour had been unacceptable, and it wouldn't be tolerated in the pharmacy. The SI said targets were set for New Medicine Service (NMS), but team members weren't put under pressure to achieve them.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy provides a professional environment for people to receive healthcare services. It has private consultation rooms that enables people with the opportunity to receive services in private, and have confidential conversations with members of the pharmacy team.

Inspector's evidence

The pharmacy was adjacent to a medical centre and there was an entrance between them. The premises, including the shop front and facia, were clean, well maintained and in a good state of repair. The retail area was free from obstructions, professional in appearance and had a waiting area with six chairs. A cleaning rota was used. The temperature and lighting were adequately controlled. The pharmacy was fitted out to a high standard, and the fixtures and fittings were in good order. Maintenance problems were reported to the SI and the response time was appropriate to the nature of the issue.

There was a separate stockroom where excess stock was stored. Staff facilities included a small kitchen area, and a WC, with a wash hand basin and hand wash. There was a separate dispensary sink for medicines preparation with hot and cold running water. Hand washing notices were displayed above the sinks.

There were two consultation rooms which were locked when not in use. The availability of the rooms was highlighted by a sign on the doors. One of the rooms was used when carrying out services such as vaccinations and when customers needed a private area to talk. The other room was mainly used as an office. An area of the counter was screened which allowed a degree of privacy when prescriptions were being handed out.

Principle 4 - Services ✔ Good practice

Summary findings

The pharmacy offers a wide range of healthcare services which are tailored to the local community and are easy for people to access. It manages its services safely to help make sure people receive effective care. The pharmacy team members promote services to help improve people's health and wellbeing. They work collaboratively with other healthcare professionals, and they engage people in quality conversations about their health leading to positive outcomes. The pharmacy sources and supplies medicines safely. And it carries out checks to ensure medicines are in good condition and suitable to supply.

Inspector's evidence

The pharmacy was accessible to everyone, including people with mobility difficulties and wheelchair users. There was a wide entrance with shutters which led into the medical centre. A list of the services provided by the pharmacy was displayed in the window, along with the opening hours. The pharmacy team was clear what services were offered and where to signpost people to a service not offered. For example, needle exchange. A folder was available containing relevant signposting information which could be used to inform people of services and support available elsewhere, and signposting was recorded. The pharmacy was a healthy living pharmacy and there was a range of healthcare leaflets and posters advertising local services. The pharmacy assistant apprentice was responsible for coordinating the healthy living resources. The SI helped create a hypertension service form which had been extended to include a healthy heart campaign, capturing blood pressures (BPs), weight and BMI. This information was passed onto the patient's GP, with consent, and allowed a greater safety net for those that had not been seen by their GPs over the last few years. There was a machine to test hearing in the pharmacy which allowed people to have a free hearing test and access an audiology service. The SI explained there was a link with loss of hearing to Dementia so this was an important service for elderly people in the community.

The pharmacy had vaccinated over 90,000 people with the Covid-19 vaccination from an associated site at a church hall and a mobile vaccination vehicle. The pharmacy had done this with the support of 80 local volunteers. The team had supported people who had reactions to the vaccines, some of which had required hospitalisation due to anaphylaxis reactions, and the team members had helped many fainters. The SI explained that the vaccinations clinics had led to great opportunities to improve outcomes for patients and tackle inequalities. Using an NHS parked van which was run by a team of nurses and pharmacists employed by the pharmacy, they had over 100 separate clinics and supported patient areas where the uptake of the vaccination has been lower than the national average. The SI explained that he worked with the Derbyshire Medicines Management team and Public Health England to create health engagement in areas where English was not the first language, such as an Eastern European community, where many people had not engaged with the health network or even signed up with a GP. The pharmacy received a lot of positive feedback about this work and there were some positive outcomes for patients. During one event, a team member came across a young person who did not want a vaccine, but they were encouraged to check their weight and undertake a BP check. This identified an elevated BP and possible atrial fibrillation (AF) resulting in an immediate referral to hospital, where the person underwent a procedure to improve their health.

There was a home delivery service with associated audit trail. The service had been adapted to

minimise contact with recipients, during the pandemic. The delivery driver confirmed in their records when a delivery had been successful. A note was left if nobody was available to receive the delivery and the medicine was returned to the pharmacy. If the prescription contained a CD, then a special CD delivery sheet would be completed, and the delivery driver would obtain a signature from the person receiving the delivery.

Space was quite limited in the dispensary, but the workflow was organised into separate areas with a designated checking area. The dispensary shelves were well organised, neat, and tidy. Dispensed by and checked by boxes were initialled on the medication labels to provide an audit trail. The RP initialled or stamped prescriptions to indicate they had completed a clinical check before the ACT was allowed to carry out an accuracy check. Different coloured baskets were used to improve the organisation in the dispensary and prevent prescriptions becoming mixed up. The baskets were stacked to make more bench space available.

Stickers were put on assembled prescription bags to indicate when a fridge line or CD was prescribed. 'Pharmacist' stickers were used to highlight when counselling was required and high-risk medicines such as warfarin, lithium and methotrexate were targeted for extra checks and counselling. INR levels were requested and recorded when dispensing warfarin prescriptions. The pharmacy reported INR readings to the GP surgery for people who collect their warfarin medication from the pharmacy. The pharmacist described a positive intervention when they had immediately referred a person who was taking warfarin for an INR check as they were experiencing possible side effects. This had resulted in their medication being changed.

The team were aware of the valproate pregnancy prevention programme. The valproate information pack and care cards were available to ensure people in the at-risk group were given the appropriate information and counselling. The pharmacy had a good working relationship with the medical centre next door which was a six GP practice. Records of referrals to GPs and interventions were maintained and recorded on the patient's medication record (PMR).

Multi-compartment compliance aid packs were well managed. The GP practice was required to complete a 'notification of change' form when any changes were made to a person's medication in compliance aid packs. If a change was made and a form had not been provided, the pharmacy contacted the practice pharmacist or pharmacy technician and arranged for a form to be completed before the team assembled the compliance aid pack. The form was used to create an audit trail of medication changes. Medicine descriptions were included on the labelling sheet to enable identification of the individual medicines. A team member confirmed packaging leaflets were included but cautionary and advisory labels were not on the labelling sheet so people might not always have all the information they need. The SI said he would ensure an adjustment was made to the labelling system to ensure that these labels were added. A dispensing audit trail was completed, and disposable equipment was used. The pharmacy carried out a needs assessment to ensure all adjustments had been considered before initiating a patient on a compliance aid pack. The SI described sharing his learning with pharmacies and surgeries within the PCN at a medicine management meeting to ensure pharmacies were not automatically given a compliance aid pack upon request.

The pharmacy assistant apprentice was clear which medicines could be sold in the presence and absence of a pharmacist and understood what action to take if he suspected a customer might be misusing medicines such as a codeine containing product. He explained what questions he asked when making a medicine sale and when to refer the person to a pharmacist. The SI described an occasion when he had made an intervention and contacted a person's GP due to concerns about their use of Viagra and other associated symptoms. The person had subsequently been diagnosed with early stages of prostate cancer and was grateful for the intervention.

CDs were stored in four CD cabinets which were securely fixed to the wall. One CD cabinet was for assembled prescriptions awaiting collection. CDs were stored in clear plastic bags which also contained the prescription form, so these could be double checked before hand-out. Once dispensed the prescription form was placed in a designated basket and either the PT or ACT made the entries in the electronic register at the end of the day. The CD keys were under the control of the responsible pharmacist during the day and stored securely overnight. Anyone accessing the CD cabinets during the day were required to enter their name and the details on a log. Date expired, and patient returned CDs were segregated and stored securely. Patient returned CDs were destroyed using denaturing kits. Pharmacy medicines were stored behind the medicine counter so that sales could be controlled.

Recognised licensed wholesalers were used to obtain stock medicines and appropriate records were maintained for medicines ordered from 'Specials.' The invoices were separated into the different wholesalers and stored in separate boxes. CD invoices were stored separately. Medicines were stored in their original containers at an appropriate temperature. Date checking was carried out and documented. Short-dated stock was highlighted. Expired and unwanted medicines were segregated and placed in designated bins.

Alerts and recalls were received via email messages from the Medicines & Healthcare products Regulatory Agency (MHRA). These were read and acted on by a member of the pharmacy team and then filed. A copy was retained in the pharmacy with a record of the action taken so the team were able to respond to queries and provide assurance that the appropriate action had been taken.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

Members of the pharmacy team have access to the equipment and facilities they need for the services they provide. They maintain the equipment so that it is safe to use.

Inspector's evidence

The pharmacist could access the internet for the most up-to-date information. For example, the electronic British National Formulary (BNF) and BNF for children. The SI said he frequently used the electronic medicines compendium (eMC) website.

There were two clean medical fridges for storing medicines. One was for stock, and one was for assembled prescriptions awaiting collection. The minimum and maximum temperatures were being recorded regularly and had been within range throughout the month. All electrical equipment appeared to be in good working order and had been PAT tested.

There was a large selection of clean glass liquid measures with British standard and crown marks. Separate measures were marked and used for methadone solution. The pharmacy had a range of clean equipment for counting loose tablets and capsules. There was a separate marked tablet triangle that was used for cytotoxic drugs, which was stored in a clear plastic bag.

Computer screens were positioned so that they weren’t visible from the public areas of the pharmacy. Patient medication records (PMRs) were password protected. Cordless phones were available in the pharmacy, so staff could move to a private area if the phone call warranted privacy.

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.