

Registered pharmacy inspection report

Pharmacy Name: Well, Unit 12 Jamage Road, Talke Pits, STOKE-ON-TRENT, Staffordshire, ST7 1QD

Pharmacy reference: 1092979

Type of pharmacy: Community

Date of inspection: 08/01/2020

Pharmacy context

This is a busy pharmacy located in a shopping centre. The pharmacy dispenses NHS prescriptions and sells a range of over-the-counter medicines. It supplies a large number of medicines in multi-compartment compliance aid packs to help people take their medicines at the right time. A large number of prescriptions are sent to the company's hub to be dispensed.

Overall inspection outcome

✓ **Standards met**

Required Action: None

Follow this link to [find out what the inspections possible outcomes mean](#)

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 adequately manages risks and members of the pharmacy team are clear about their roles and responsibilities. They have written procedures on keeping people's private information safe and complete training, so they know how to protect children and vulnerable adults. The team takes some action to improve patient safety but does not always effectively review mistakes, so may be missing out on learning opportunities. The pharmacy generally keeps the records required by law, but some details are missing, which could make it harder to understand what has happened if queries arise.

Inspector's evidence

The pharmacy had up-to-date standard operating procedures (SOPs) for the services provided. Members of the pharmacy team confirmed electronically via an e-Learning system that they had read and accepted the procedures and completed an assessment to test understanding of each SOP. Roles and responsibilities of were set out in SOPs and the pharmacy team members were performing duties which were in line with their role. Team members were wearing uniforms and name badges showing their role. The incorrect name of the responsible pharmacist (RP) was displayed at the start of the inspection, which might cause confusion in the event of a query or problem. This was rectified when pointed out to the RP.

Dispensing incidents were reported on Datix intranet, which could be viewed at the pharmacy superintendent's (SI) office. One of the errors recorded in December 2019 was a picking error involving amitriptyline 10mg and amlodipine 10mg. The actions taken to avoid re-occurrence were to include the incident in the monthly patient safety review and check the dispensary shelves to ensure the two medicines were adequately separated. However, the patient safety review had not been followed through as the shelves containing these two medicines were disorganised and untidy. Three near misses had been recorded on Datix in November 2019, although none had been recorded in October or December 2019. The pharmacy manager said near misses were not being routinely recorded and monthly patient safety reviews were not completed because the pharmacy was very busy and there had been some recent changes to the team. 'Safe and well' bulletins were sent from the SI office sharing learning within the organisation. The pharmacy manager explained that the pharmacy team were supposed to read and discuss these, but this hadn't happened recently due to the staffing situation. Clear plastic bags were used for assembled compliance packs, CDs and insulin to allow an additional check at hand out.

There were 'Customer Care' notices on display near the medicine counter and in the consultation room and these gave the details of head office, in case of a complaint and it also encouraged customers to give feedback. A customer satisfaction survey was completed annually. The results of the survey carried out in 2017 were on display and the results of the survey carried out in 2018 were available on www.NHS.uk website. In this survey 100 % of respondents had rated the pharmacy very good or excellent. Areas of strength (100%) included staff overall and the service received from staff. There were no areas identified which required improvement. Results from a 2019 survey were not available.

Professional indemnity insurance was in place. Private prescription records and the RP record were appropriately maintained, although the RPs were not recording short absences from the premises. For

example, when using the shopping centre's WC. Records of CD running balances were kept in the controlled drug (CD) register and these were regularly audited. Two CD balances were checked, and one discrepancy was found, which was due to a missed entry the previous day. The prescription had been filed but an entry of the supply had not been made in the register. The pharmacy manager said she would have realised there had been a missing entry when she next checked the running balance, which was done on a weekly basis. She said this was a priority and she would come in on her day off to carry out the checks if necessary. She couldn't explain why the entry had not been made the previous day but suggested that not having a consistent pharmacy team increased the likelihood of errors like this occurring. Patient returned CDs were recorded and disposed of appropriately.

The pharmacy team completed annual training on confidentiality. Confidential waste was placed in designated bins which were collected by a specialised disposal company. A dispenser correctly described the difference between confidential and general waste. The delivery driver knew what it meant to maintain patient confidentiality and the delivery sheet was designed to prevent people seeing other patients' details, when they signed for their deliveries. Assembled prescriptions awaiting collection were not visible from the medicines counter. Paperwork containing patient confidential information was stored appropriately. A privacy statement was on display, in line with the General Data Protection Regulation (GDPR). The pharmacy sent patient's prescriptions to their hub without obtaining explicit consent from the patient which was a potential breach of the patient's confidentiality. The pharmacy manager believed that the company's position was that the patient was assumed to have opted in, unless they specifically requested to opt out. The pharmacy also sent patients' prescriptions to Wardles, a registered dispensing appliance contractor, for them to dispense but consent was not requested or recorded for this practice either.

The pharmacy manager had completed Centre for Pharmacy Postgraduate Education (CPPE) level 2 training on safeguarding a couple of years ago and was in the process of repeating it. The delivery driver said he would voice any concerns regarding vulnerable people to the pharmacist working at the time. He gave an example of how he had assisted a patient he had found collapsed on the floor and then called an ambulance. There was a safeguarding resource on the intranet which could be accessed for advice. The pharmacy had a chaperone policy, and this was highlighted to patients. Members of the pharmacy team had completed Dementia Friends training, so had a better understanding of patients living with this condition.

Principle 2 - Staffing ✓ Standards met

Summary findings

The pharmacy team members have the right qualifications for the jobs they do, and they get some ongoing training to help them keep up to date. They receive feedback about their own performance and can raise concerns to their manager or an independent team. The pharmacy has enough staff to manage its workload but it is currently relying on relief staff. So there is a lack of continuity and time to complete training and some non-urgent tasks.

Inspector's evidence

There was a pharmacy manager who was working as the RP, two NVQ2 qualified (or equivalent) relief dispensers, a pharmacy student and a delivery driver on duty at the time of the inspection. The staffing level was adequate for the volume of work during the inspection. It was the pharmacy manager's first week in this role, but she was familiar with the pharmacy as she completed her pre-registration training there. Three of the pharmacy's dispensers were absent due to sickness so two relief dispensers were working. One had recently joined the company and she confirmed she had read the SOPs. The other explained that he had worked one or two days each week in the pharmacy over the last month and had previously provided holiday cover, so knew the pharmacy reasonably well. The pharmacy manager explained that there had been some redundancies and another member of the team recently left, so as well as absences due to sickness, there was also a current vacancy for a dispenser of around 23 hours. This vacancy was being temporarily covered by relief staff. A regional support manager was present for some of the inspection and explained that he managed the resources of the relief team. He organised four-week staff rotas for the 24 branches in the region as well as individual rotas for members of the relief team. He said he was aware of the challenging situation the pharmacy was in with regards to staffing, and this was one of the branches he was prioritising. He printed off the four-week staff rota for the branch showing the names and hours of the relief team members he had planned in. He explained that he was an accuracy checking technician (ACT) himself and assisted in the pharmacy as much as possible. An additional ACT arrived during the inspection from a neighbouring branch to provide further support.

Staff carrying out services had completed appropriate training and used the company's on-line training system e-Expert learning to keep their knowledge up to date. Staff were able to display their 'learning plan' which was a record of their completed training and included reading SOPs. Very little training had been completed recently because of the staffing issues and the pharmacy manager said she was aware that the team had two new SOPs which they needed to read, and this was outstanding.

Team members had formal discussions with the pharmacy manager about performance and development. These were carried out by the regional support manager for the relief team, including the relief pharmacists. Communication within the company was via the intranet and there was an online alerting system, 'Merlin' which highlighted when new information was available such as messages from the SI's office and alerts and recalls. Daily, weekly and monthly tasks were assigned via this system. The pharmacy manager said she would be holding team huddles where issues would be discussed and information from bulletins and conference calls would be cascaded to the team. Concerns could be raised informally and there was a 'speak up' notice, where staff were encouraged to raise any concerns with their line manager and also gave the details of an independent whistleblowing service.

The pharmacy manager said she felt empowered to exercise her professional judgement and could comply with her own professional and legal obligations. For example, refusing to sell a pharmacy medicine containing codeine, because she felt it was inappropriate. She said individual and team targets were set for services such as Medicines Use Reviews (MURs). She felt there was a lot of pressure on her now she was pharmacy manager to achieve these targets. But she didn't feel targets ever compromised patient safety and thought the regional development manager would be supportive and understanding of the current situation.

Principle 3 - Premises ✓ Standards met

Summary findings

The premises generally provide a professional environment for people to receive healthcare. The pharmacy has a private consultation room that enables it to provide members of the public with the opportunity to have confidential conversations.

Inspector's evidence

The pharmacy premises including the shop front and fascia were well maintained and in a good state of repair. The retail area was spacious, free from obstructions, professional in appearance and had a waiting area with two chairs. The temperature and lighting were adequately controlled. The pharmacy had been fitted out to a good standard when it opened and the fixtures and fittings were in good order. Maintenance problems were reported to Well support centre and the response time was appropriate to the nature of the issue.

Staff facilities included a separate room with a kitchen area. This room was also used to store stock, compliance aid packs and waste medicines. There was no WC on the premises so the pharmacy team were required to use the shopping centre's staff communal WCs, meaning the RP was absent from the premises at times, and services and sales of pharmacy medicines could be delayed. There was a separate dispensary sink for medicines preparation with hot and cold running water. Hand washing notices were displayed above the sinks. Hand sanitizer gel was available.

There was a consultation room which was reasonably clean and professional in appearance. The availability of the room was highlighted by a sign on the door and in the pharmacy's window. Staff used the room when carrying out the services and also when customers needed a private area to talk. There was a separate part of the medicine counter, with a screen, which allowed a degree of privacy when prescriptions were being handed out.

Principle 4 - Services ✓ Standards met

Summary findings

The pharmacy's services are easily accessible and generally well-managed, so people receive appropriate care. The pharmacy gets its medicines from reputable sources and carries out some checks to ensure they are in good condition. But medicines are not always stored in an orderly manner, which might increase the risk of errors.

Inspector's evidence

The pharmacy, consultation room and pharmacy counter were accessible to all, including patients with mobility difficulties and wheelchair users. There was a large open entrance from the shopping centre. There was a hearing loop in the pharmacy and a sign indicating this.

The flu vaccination service was being promoted but other services provided by the pharmacy were not advertised, so people might not realise they were available. There was a health promotion zone with information supporting the 'stay well this winter' campaign. There was a range of healthcare leaflets on conditions such as asthma and substance misuse. Staff were clear what services were offered and where to signpost to a service not offered. For example, the ear, nose, throat and eye extended care service which was offered by a neighbouring pharmacy. A folder was available containing relevant signposting information which could be used to inform patients of services and support available elsewhere. Signposting and providing healthy living were not recorded so it was difficult for staff to remember examples of improved patient outcomes and monitor the effectiveness of the health campaigns.

The pharmacy offered a prescription collection service and patients indicated their requirements in advance when they collected their medication. Requirements were checked again at hand-out and any unwanted medicines were retained in the pharmacy and the prescription endorsed as not dispensed. This was to reduce stockpiling and medicine wastage. There was a home delivery service with associated audit trail. Each delivery was recorded and a signature was obtained from the recipient. A note was left if nobody was available to receive the delivery and the medicine was returned to the pharmacy. The delivery driver described the delivery process which was in line with the SOP.

The work flow in the pharmacy was organised into separate areas and there was a designated checking area. Dispensed by and checked by boxes were generally initialled on the medication labels to provide an audit trail, although some compliance packs were found which did not have any record of who had dispensed or checked them. This might make it harder to work out what had gone wrong in the event of a problem. The pharmacy manager said these had been checked by locum pharmacists, who didn't always initial them. But confirmed the usual pharmacy team always initialled the compliance packs to indicate who had assembled and checked them. 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. 'Speak to Pharmacist' stickers were used to highlight counselling was required and high-risk medicines such as valproate and lithium were targeted for extra checks and counselling. INR levels were not routinely requested or recorded when dispensing warfarin prescriptions. The team were aware of the valproate pregnancy prevention programme. An audit had

been carried out and there were no patients in the at-risk group. The valproate information pack and care cards were available to ensure people in the at-risk group were given the appropriate information and counselling. An audit of patients with diabetes was being carried out and one patient had been referred for a foot check as he hadn't had one in the last year.

Multi-compartment compliance aid packs were generally well organised. There was a form to record communications with GPs and changes to medication. But it was not always clear who had confirmed the changes, which could cause confusion in the event of a query. Medicine descriptions were usually included on the labels to enable identification of the individual medicines and packaging leaflets were included, so patients and their carers had easy access to information about their medicines. Disposable equipment was used. A suitability form was available to record an assessment made by the pharmacist as to the appropriateness of a compliance aid pack, or if other adjustments might be more appropriate to the patient's needs.

The pharmacy student explained what questions to ask when making a medicine sale and when to refer the patient to a pharmacist. He 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 abusing medicines such as a codeine containing product. CDs were stored in two CD cabinets which were securely fixed to the wall/floor. The keys were under the control of the responsible pharmacist during the day and stored securely overnight. 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.

Space was adequate in the dispensary, but the benches were cluttered and some of the dispensary shelves were full and untidy. Some medicines of different strengths were mixed together, which increased the risk of error. Some medicines were stored on the floor due to lack of space on the dispensary shelves. This was unhygienic and risked physical damage to the medicines and was a trip hazard. Medicines were generally stored in their original containers. But two or three foil strips were seen on the dispensary shelves which were not in their original containers, so it might not be clear what they were and their expiry date and batch number was missing. The pharmacy manager said this should not happen and the usual pharmacy team knew this. There was a procedure for date checking which was recorded electronically. The pharmacy manager explained the team had fallen behind with this, but she was aware of this and was attempting to catch up. An incident had occurred in December 2019 when a date expired medicine had been supplied, which highlighted the importance of routine date checking. Dates had been added to opened liquids with limited stability, to ensure they were fit to use. Designated bins were available to dispose of expired medicines.

Recognised licensed wholesalers were used to obtain medicines and appropriate records were maintained for medicines ordered from 'Specials'. No extemporaneous dispensing was carried out. The pharmacy was not compliant with the Falsified Medicines Directive (FMD). It had the software or hardware needed to comply and the team members had received some training but were not currently scanning to verify or decommission medicines. They were still waiting for a decision from head office about when to initiate this. Alerts and recalls were received via 'Merlin' from the superintendent's office and could also be viewed directly from the intranet. These were read and acted on by the pharmacist or a member of the pharmacy team and then filed.

Principle 5 - Equipment and facilities ✓ Standards met

Summary findings

Members of the pharmacy team have 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

Current versions of the British National Formulary (BNF) and BNF for children were available and the pharmacist could access the internet for the most up-to-date information. There was a clean medical fridge. The minimum and maximum temperatures were being recorded daily and had been within range throughout the month. All electrical equipment appeared to be in good working order and had been PAT tested. Equipment was ordered through the Well support centre at head office and any problems with equipment, including IT, would be dealt with by them.

There was a selection of clean liquid measures with British Standard and crown marks. A separate measure was marked and used for CDs. The pharmacy had equipment for counting loose tablets and capsules and a separate marked tablet triangle that was used for cytotoxic drugs. Medicine containers were appropriately capped to prevent contamination. Sharps bins were available in the consultation room for use in the flu vaccination service.

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.