General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Medicines + Pharmacy, 41 High Street, Navenby, LINCOLN, Lincolnshire, LN5 0DZ

Pharmacy reference: 1093357

Type of pharmacy: Community

Date of inspection: 01/09/2022

Pharmacy context

This community pharmacy is in the rural Lincolnshire village of Navenby. The pharmacy's main services include dispensing prescriptions and selling over-the-counter medicines. It supplies some medicines in multi-compartment compliance packs, designed to help people to take their medicines. And it delivers some medicines to people's homes.

Overall inspection outcome

Standards not all met

Required Action: Improvement Action Plan

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 not all met	2.2	Standard not met	Not all pharmacy team members progress through and complete training relevant to their current role in a timely manner. There is evidence that team members complete some tasks without having completed the necessary learning to support them in ensuring the tasks are carried out safely and effectively.
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 generally identifies and manages the risks associated with its services appropriately. It keeps people's private information secure and it advertises how people can feedback about its services. Pharmacy team members know how to recognise and respond to safeguarding concerns. They discuss the mistakes they make during the dispensing process. But they do not always record these mistakes to help inform regular reviews. This means they may miss opportunities to share learning and to inform actions designed to improve patient safety.

Inspector's evidence

The pharmacy had standard operating procedures (SOPs) in place to support the safe running of the pharmacy. These were a number of years old but the superintendent pharmacist had reviewed them at scheduled intervals, with the last review documented as 2021. The majority of team members had read and signed SOPs associated with the tasks they undertook. And new team members were in the process of reading and signing them. But due to a high number of team members in training roles there was some inconsistencies in how some tasks were completed. For example, the SOP related to the multi-compartment compliance pack service specified a team member should 'create or update' a record sheet during the dispensing process. But there had been instances of medicines being omitted from compliance packs. And some record sheets contained multiple amendments that could increase the risk of missing a change.

The pharmacy had tools to support its team members in recording near misses and dispensing incidents. But near miss reporting was inconsistent, with no recent near miss records available for inspection. And there was some reliance on verbal feedback following minor mistakes such as selecting capsules rather than tablets during the dispensing process. Team members working in the dispensary were in training roles which increased the likelihood of a mistake occurring. A discussion took place about the importance of consistently reporting near misses in order to share learning and to identify risk reduction actions designed to improve patient safety. Pharmacy team members used the patient medication record (PMR) system to record details of dispensing incidents, and these were reported to the superintendent pharmacist (SI). The RP on duty was aware of a recent incident, but was waiting for formal feedback about specific details of the incident and any findings from the investigation process in order to support the team in applying learning following the incident. The team could not demonstrate any recent actions designed to reduce risk in the dispensary. But stock layout supported a safe dispensing process with 'look-alike and sound-alike' medicines clearly segregated on the dispensary shelves to reduce the risk of a picking error occurring.

The pharmacy had a complaints procedure and it advertised how people could provide feedback about its services. And team members understood how to manage and escalate a concern to the attention of the RP or SI if required. Pharmacy team members were observed being attentive to people's needs with requests for advice and support with medicines managed in a timely manner. But team members were seen to be subjected to verbal abuse from members of the public regarding the unavailability of medicines, due to problems in the supply chain. A discussion took place about the availability of NHS display materials urging people to treat team members providing primary healthcare services with respect. The pharmacy had safeguarding procedures in place, and its team members understood the importance of sharing safeguarding concerns with other healthcare professionals involved in a person's

care. A team member provided several examples of how they had sought support from the RP when they had concerns that somebody may be vulnerable. And team members acted to share concerns with other healthcare professionals when appropriate. The RP had completed level two safeguarding learning through the Centre for Pharmacy Postgraduate Education.

The pharmacy had up-to-date indemnity insurance arrangements in place. The RP notice displayed the correct details of the RP on duty. The CD register was generally maintained in accordance with legal requirements. The pharmacy maintained running balances in the CD register but physical balance audits against the register were infrequent. A recent full balance audit had been completed in August 2022. A random balance check conformed to the balance recorded in the register. Other records contained some omissions and inaccuracies. For example, RPs did not always sign into the RP record at the time they commenced their role, and they did not always sign-out of the record. The pharmacy held its private prescription record electronically. But there were some omissions in the register due to prescriptions being incorrectly labelled on the PMR system as an NHS or dental prescription. This meant it may be more difficult for the pharmacy to investigate and resolve queries it received. The pharmacy had procedures in place to support the safe handling of patient information. The team held personal identifiable information on computers and within areas of the pharmacy only accessible to staff. Confidential waste was held securely and shredded.

Principle 2 - Staffing **Standards not all met**

Summary findings

The pharmacy is highly reliant on trainee team members to support the delivery of its services. Not all pharmacy team members progress through and complete training relevant to their current role in a timely manner. And there is evidence that team members complete some tasks which they are not competent in. Pharmacy team members understand how to raise concerns at work. And they engage in some ongoing discussions to share ideas and learning.

Inspector's evidence

The pharmacy generally used regular locum pharmacists to support it in providing its services, it had not had a full-time regular pharmacist for some time. But it had recently employed a pharmacist due to commence in a management role shortly The pharmacy employed two delivery drivers, an apprentice, three trainee dispensers and two new team members. One new team member was at the end of their induction period and due to be enrolled on accredited training to support them in their role, the other had worked at the pharmacy for approximately four weeks.

There was a large reliance on trainee team members to support the delivery of pharmacy services. And there was some confusion between team members about the actual course they were enrolled on to support their learning and development. Progress towards completing courses had been affected significantly by both the pandemic and high staff turnover within the last year. For example, one team member who had worked at the pharmacy for several years was currently working through the medicine counter assistant part of a combined training course but spent the majority of their working time in the dispensary. They did not have protected training provided at work, and had not progressed to the dispensary section of the course to support their current role. Another team member had started a dispensary training course but had not progressed through the course and was undertaking higher risk tasks associated with the supply of medicines in multi-compartment compliance packs.

Following the inspection the SI provided some assurances around supervision of team members working in the dispensary. And confirmed the pharmacy had a training plan in place which they were personally overseeing. But there was evidence that not all team members were competent in completing the tasks they were assigned. For example, the issue with the incomplete private prescription register identified not all team members were processing private prescriptions correctly when labelling them. And a team member had incorrectly submitted a dispensed notification, claiming for a controlled drug prescription that the pharmacy had not supplied. The incident also meant the pharmacy was unable to return the prescription to the NHS spine and as such this had caused additional work for both the pharmacy and the GP surgery. Current training needs also put pressure on RPs. For example, the risk of a mistake being made during the dispensing process was heightened as RPs completed some tasks associated with both assembling and checking medicines. For example, reconstituting liquid medicines.

The pharmacy team generally communicated through verbal conversations. But the team did not regularly review risk and share learning through a structured process, designed to support continual improvement. The pharmacy had a whistleblowing policy and a guidance document was provided to support team members in raising concerns at work. But not all team members were aware of this

document and how to access it. Pharmacy team members reported feeling able to provide feedback and raise concerns at work. But they were not always aware if their feedback was used to inform the way the pharmacy provided its services. The pharmacy did not set specific targets for its team members to meet.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean, secure, and suitable for the services provided. It has facilities to allow people to have a private conversation with a member of the pharmacy team.

Inspector's evidence

The pharmacy was secure and in a sufficient state of repair. And it had appropriate lighting, heating, and ventilation arrangements. A portable air conditioning unit in the dispensary helped to ensure a suitable environment for working and for storing medicines. Team members had access to hand washing facilities and antibacterial hand gel. The pharmacy premises consisted of a good size, open plan public area. The medicine counter was protected by a robust plastic screen, this helped to prevent the risks associated with providing pharmacy services during a pandemic. A good size consultation room was accessible close to the entrance of the pharmacy. But boxes and paperwork stored in the room did deter from its overall professional appearance. The dispensary was located up a step and through a doorway behind the medicine counter. The dispensary was a sufficient size with some protected space for completing tasks associated with the multi-compartment compliance pack service. Workflow within the main area of the dispensary was suitably managed.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's services are accessible to people. It keeps audit trails to help its team members answer any queries that may arise. And the pharmacy team provides advice to people when supplying medicines to them. The pharmacy obtains its medicines from reputable sources. And it generally stores them safely and securely. But pharmacy team members do not always keep records of the stock checks they make to ensure medicines remain fit to supply to people.

Inspector's evidence

The pharmacy was accessed through a door, up a step from street level. There were two further steps, spaced out in the public area of the pharmacy. Team members explained that they were able to assist people with entry to the premises or would serve people at the pharmacy door when required. The pharmacy provided seating for people waiting for prescriptions or a service. And its team members signposted people to another pharmacy or healthcare provider if they were unable to provide a service. A team member was observed liaising with another local pharmacy to ensure it had stock of a medicine prior to signposting a person to the pharmacy.

The pharmacy protected Pharmacy (P) medicines from self-selection as it displayed them behind the medicine counter. And there was good supervision of sales taking place at the medicine counter as each request was brought to the attention of the RP. The RP was observed supporting team members and responding to people's queries by speaking to them in a timely manner about their health or the medicines they were taking. This included providing verbal counselling when handing out assembled medicines. The pharmacy had safety materials associated with the valproate pregnancy prevention programme readily available to issue to people. The RP was aware of the requirements of the programme. And discussed how the pharmacy engaged in audits relating to the supply of higher risk medicines. But the team didn't record the details of any counselling or monitoring checks completed on people's PMRs.

The pharmacy used coloured baskets throughout the dispensing process. This kept medicines with the correct prescription form and identified medicines requiring delivery to people's homes. Pharmacy team members took ownership of their work by signing their initials in the 'dispensed by' and 'checked by' boxes on medicine labels. The pharmacy team kept prescriptions for medicines owing to people. And used the prescription throughout the dispensing process when the medicine was later supplied. It kept electronic audit trails to support the delivery of medicines to people's homes. This supported the team in answering queries related to the delivery service.

The pharmacy provided medicines in multi-compartment compliance packs to some people. It used a planner to help ensure people received their medicine in a timely manner. The pharmacy used individual record sheets to record people's medicine regimens. These were generally updated with details of tracked changes when a person's medication regimen changed. But some sheets contained multiple amendments and were becoming difficult to read. The pharmacy also held record sheets for people it no longer provided the service to. It stored these records amongst current record sheets and this had the potential to cause confusion. Assembled packs contained dispensing audit trails and clear descriptions of the medicines inside. But the pharmacy did not routinely provide patient information

leaflets when making supplying medicines in compliance packs. This may mean people did not have all the information required to support them in using their medicine safely.

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. There was a small number of medicines stored in loose blisters next to their original packaging. This was not ideal but the blisters did contain clear identifiable information. For example, details of the medicine including the batch number and expiry date. Pharmacy team members reported completing date checking tasks during quieter periods. But there was no record in place to support the team in ensuring these checks took place regularly. A random check of dispensary stock found an out-of-date medicine, this was segregated with other out-of-date medicines recently removed from the dispensary shelves. Pharmacy team members explained they checked expiry dates during the dispensing process to help ensure a medicine remained safe and fit to supply to a person. The pharmacy had appropriate medical waste receptacles available. There was some build-up of sharps waste in an area of the dispensary. The sharps had been segregated during a recent date checking exercise and were awaiting destruction. The pharmacy received medicine alerts through email. The SI processed these alerts and cascaded the details to team members to ensure timely checks of stock were made prior to actioning the alert.

The pharmacy held CDs in secure cabinets. But storage for stock medicines was compromised due to a high number of out-of-date CDs awaiting destruction. There was a need for the pharmacy to arrange an authorised witness to visit to support the safe destruction of these medicines. The pharmacy held cold chain medicines in a medical fridge, the fridge was clean and was a suitable size for the amount of medicines held. A second fridge in the consultation room was used to hold some assembled medicines, and the team planned to store flu vaccines in this fridge when the vaccination season commenced. It monitored the temperature of both fridges, but it had not set up a temperature record for the fridge in the consultation room. Team members reported that the fridge was new. There were some gaps within the fridge temperature record associated with the dispensary fridge. But the temperature range either side of these gaps had remained within two and eight degrees Celsius as required.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs to provide its services. Its 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 reference resources available. These included the British National Formulary (BNF). Pharmacy team members could access the internet to help resolve queries and to obtain up-to-date information. For example, the RP was observed accessing and printing patient information leaflets to supply to people when there was a need to split the manufacturer's original packaging when supplying a medicine. The pharmacy's computer was password system protected. And information displayed on computer monitors in the dispensary and at the medicine counter could not be viewed by unauthorised personnel. The pharmacy stored bags of assembled medicines in boxes behind the medicine counter. This arrangement prevented information on bag labels and prescription forms being visible from the public area. The pharmacy had a range of equipment available to support the delivery of its services. But one crown stamped measuring cylinders was heavily marked and required descaling or replacing.

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.