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: 26/04/2023

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 also operates a COVID-19 vaccination service from the premises. 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 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 acts to identify and manage risks associated with providing its services. It generally keeps the records it needs to by law in good order. And it protects people's confidential information appropriately. Pharmacy team members know how to respond to people's feedback. They understand how to raise a concern about a vulnerable person to help keep them safe from harm. And they engage in some learning to reduce risk following the mistakes they make during the dispensing process.

Inspector's evidence

The pharmacy had standard operating procedures (SOPs) to support the safe running of the pharmacy. These had been created a number of years ago. The superintendent pharmacist (SI) had reviewed them at scheduled intervals, with the last review documented as 2021. Recent procedures were available to support the delivery of the COVID-19 vaccination service. The majority of team members had read and signed SOPs associated with the tasks they undertook. And they were observed working within their respective roles. All team members on duty were trainees and as such kept the responsible pharmacist (RP) informed of the tasks they were undertaking and asked for support when required. For example, by asking for an accuracy check of water measured to reconstitute an antibiotic oral solution. A team member discussed the tasks that could not be completed should the RP take absence from the pharmacy. And the SI discussed details of safeguards on the patient medication record (PMR) system to ensure dispensing tasks didn't start unless a RP was signed in.

The pharmacy had tools to support its team members in recording mistakes made and identified during the dispensing process, known as near misses. Near miss reporting had increased significantly following the last inspection of the pharmacy in September 2022. A team member reflected on how reporting helped the team to learn from its mistakes and supported it in identifying and managing risk. And several team members explained that having an awareness of their own patterns in mistakes helped prompt additional checks when completing dispensing tasks. The team discussed near misses to help share learning. But it did not document the details of these discussions. This meant it might be more difficult to measure the effectiveness of the actions it took to reduce risk. The RP provided a comprehensive summary of how they would respond to, investigate, and report a mistake identified following the supply of a medicine to a person, known as a dispensing incident. Pharmacy team members used the PMR system to record details of dispensing incidents, and the team reported them to the SI. The RP on duty shared concerns about the risk of a mistake occurring due to the PMR printing a dispensing label and an owing label when the pharmacy didn't have a medicine in stock. Team members on duty responded to this concern by taking the opportunity to identify how they could utilise functions on the PMR system to prevent a dispensing label printing initially when the full quantity of a medicine was owed.

The pharmacy had a complaints procedure and it advertised how people could provide feedback about its services. Its team members understood how to manage and escalate a concern to the attention of the RP or SI if required. The pharmacy was exceptionally busy throughout the inspection due to the COVID-19 vaccination service operating. Pharmacy team members were observed being attentive to people's needs with requests for advice and support with medicines managed in a timely manner. People waiting for vaccinations appeared content and were supported by a dedicated vaccination

assistant (a trainee medicine counter assistant). The pharmacy had safeguarding procedures in place. And its team members understood how to recognise, and report concerns about vulnerable people. The SI had completed safeguarding learning. The RP had completed some historic learning and expressed that they felt confident in seeking support and reporting a safeguarding matter if a concern was brought to their attention.

The pharmacy had current indemnity insurance arrangements and the SI provided assurances that these arrangements covered the COVID-19 vaccination service. The RP notice displayed the correct details of the RP on duty. The controlled drug (CD) register was maintained in accordance with legal requirements. The pharmacy maintained the register with running balances, but these were not regularly checked against physical stock levels. Several random physical balances conformed to the balances recorded in the register. Other samples of records such as the RP register, and the Prescription Only Medicine (POM) register found entries to be made in accordance with requirements. But the filing system for private and veterinary prescriptions dispensed was not orderly. This could make it difficult to retrieve a prescription in the event a query arose. The pharmacy had procedures to support the safe handling of people's personal information. It held personal identifiable information on computers and within areas of the pharmacy only accessible to staff. The team segregated confidential waste and held it securely onsite. The pharmacy's shredder had very recently broke and as such the team was expecting an update on future arrangements for managing this waste. No large accumulation of confidential waste was observed.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has a small team of people who work together well to deliver its services. Pharmacy team members are appropriately supervised in their roles as trainees. They recognise the importance of referring to pharmacists for support and are confident in providing feedback at work. And they engage in learning relevant to their roles.

Inspector's evidence

The pharmacy had a regular locum pharmacist who undertook the RP role most days, they were on leave at the time of inspection. The SI also worked as the RP regularly. A locum pharmacist that had worked at the pharmacy on occasion was providing RP cover during the inspection and the SI was working as the second pharmacist delivering the COVID-19 vaccination service. Both the SI and trainee medicine counter assistant were able to dedicate their time solely to supporting people's journey through the vaccination service. A delivery driver was on duty, and two trainee dispensers were completing tasks in the dispensary and serving on the medicine counter. One of these trainee dispensers held the role of pharmacy manager. The team members had to break off from dispensing tasks frequently. But they were observed completing checks of their work before continuing to complete the task they had left. The pharmacy also employed another delivery driver and a trainee dispenser.

The pharmacy had experienced a high turnover of staff during the last few years. Several team members that had left the pharmacy during the coronavirus pandemic had recently re-joined the team in training roles. All team members were either progressing through a GPhC accredited training course associated with their role or were completing induction training. The SI was aware of the requirement to enrol all team members on GPhC accredited training courses within three months of employment. There was evidence of team members completing recent e-learning at work. This learning was associated with the NHS Pharmacy Quality Scheme. Team members involved in the COVID-19 vaccination service had completed relevant learning associated with their role in delivering the service. The SI demonstrated how this learning was applied in practice when handling the vaccine once it was removed from the fridge. The RP was not given specific targets to meet whilst working at the pharmacy. They expressed that the level of supervision required to support trainee team members was high. They recognised the risks of breaking off from their work when answering queries and managed this risk well.

Pharmacy team members communicated through continual conversations at work. The pharmacy had a whistleblowing policy, and a guidance document was provided to support team members in raising concerns. But not all team members demonstrated an awareness of this policy. They described feeling supported at work. And they felt able to provide feedback and raise concerns. A team member had been authorised to apply changes to paperwork associated with the multi-compartment compliance pack service following sharing their idea.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is safe and secure and suitable for the services it provides. It offers a quiet, protected space for people who wish to speak to a member of the pharmacy team in private.

Inspector's evidence

The pharmacy was secure and in a sufficient state of repair. The premises had appropriate lighting, heating, and ventilation arrangements which were tailored to manage environmental conditions throughout the year. Team members had access to appropriate hand washing facilities and antibacterial hand sanitiser. They also had access to personal protective equipment (PPE) should they choose to wear it while working. People visiting the pharmacy as part of the vaccination service were offered a type IIR facemask.

The pharmacy premises consisted of an open plan public area. The medicine counter was protected by a plastic screen. The consultation room was accessed off the public area and was a decent size. It offered a suitable private space for speaking to people. And it was in use throughout the inspection to support the vaccination service. The team had set the reception area for the vaccination service up to the side of the medicine counter. This helped created to provide a semi-private area for completing initial screening questions associated with the service. The dispensary was located up a step and through a doorway behind the medicine counter. Available workbench space in the main dispensary was limited due to a high number of baskets containing part-completed prescriptions waiting for stock to arrive. There was protected space for completing assembly tasks and for undertaking the final accuracy check of medicines. A dedicated space to the side of the main dispensary provided a suitable area for completing tasks associated with the multi-compartment compliance pack service. Team members had access to drink making and toilet facilities within the premises.

Principle 4 - Services ✔ Standards met

Summary findings

People benefit from the range of accessible services the pharmacy provides. The pharmacy obtains its medicines from licensed sources. And it generally stores its medicines appropriately. The pharmacy team completes regular checks to ensure medicines remain safe to supply to people. And it provides advice and relevant information to help people take their medicines safely. And to support them in making decisions about their health.

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. A team member was observed supporting people with access around the public area when required. Additional seating was provided in the public area to support people waiting either before or after their vaccination. People attending for the vaccination service engaged in a series of initial screening questions to ensure they were eligible for the vaccine and were well enough to have it. This was then followed by the clinical screening questions asked by the SI during the appointment. The team member completing the initial screening process provided an information leaflet about the vaccine for people to read as they waited. And people had the opportunity to ask questions before having their vaccine. Pharmacy team members knew how to signpost people to other healthcare providers or pharmacies should they be unable to provide a service or supply a medicine.

The pharmacy protected Pharmacy (P) medicines from self-selection as it displayed them behind the medicine counter. And there was good supervision of P medicine sales with each request brought to the attention of the RP. The RP took the opportunity to intervene to seek further information or provide additional counselling alongside a sale. The pharmacy had safety materials associated with the valproate Pregnancy Prevention Programme readily available to issue to people. A team member discussed the safety checks associated with the supply of valproate to people in the at-risk group. And they demonstrated how pharmacists recorded details of the counselling and safety checks they made prior to supplying valproate. There was some evidence of wider intervention notes on the PMR system. The team was actively working to strengthen practice associated with recording the queries they made in regard to changes to medicine regimens associated with people receiving their medicine in a multi-compartment compliance pack.

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. The pharmacy kept an electronic audit trail to support the delivery of medicines to people’s homes. The pharmacy had recently started to dispense medicines to people residing in a local care home. The care home provided the pharmacy with details of the prescriptions it had ordered. This allowed the pharmacy to raise queries if there were missing items or dose changes. Regular medicines were supplied in original packs with medication administration record (MAR) sheets and patient information leaflets provided. A team member explained that the pharmacy did not supply a MAR sheet when

dispensing an interim medicine for a person residing in the care home. This was in response to feedback from the care home to state MAR sheets were not needed for these medicines.

The pharmacy provided some medicines in multi-compartment compliance packs for people. It used an effective scheduling sheet to help ensure people received their medicine in a timely manner. A team member updated the sheet at various stages of the dispensing process. For example, when the pharmacy received the prescription, when the stock was ordered and when compliance packs were assembled and checked. This supported team members in answering queries associated with the service. The pharmacy team used individual record sheets to record people's medicine regimens. A team member completing tasks associated with the service demonstrated how they were working to update profile sheets that contained multiple changes to ensure they remained legible. The team member was observed working from patient profiles at eye level, to assist them in assembling medicines into the correct time slots for people. And prescription forms were spread out above work bench level to refer to easily. A sample of assembled compliance packs contained full dispensing audit trails and clear descriptions of the medicines inside. The pharmacy routinely provided patient information leaflets to people receiving four weeks of compliance packs together. A team member explained the SI had recently led a discussion about the requirement to supply these leaflets to people receiving their medicine weekly. The team member confirmed these would begin to be provided the following week and would be provided at the beginning of each four-week cycle moving forward.

The pharmacy sourced medicines from licensed wholesalers and specials manufacturers. It stored medicines in an orderly manner, and generally within their original packaging, on shelves throughout the dispensary. A few loose capsules were found alongside blister strips within a box of medicine being used to assemble a compliance pack. A team member acted appropriately to dispose of these capsules. The pharmacy held its CDs in secure cabinets. But storage for stock medicines was extremely limited due to a high number of out-of-date CDs and some patient-returned CDs awaiting destruction. Most of these CDs had been present at the last inspection in September 2022. The pharmacy had not arranged an authorised witness to support the safe destruction of the out-of-date medicines. The pharmacy had CD denaturing kits which meant the pharmacy was in a position to safely dispose of the patient-returned CDs. The fridges were clean and a suitable size for the number of medicines held. The pharmacy monitored the temperature of both fridges, these records showed that they were operating within the required temperature range of two and eight degrees Celsius. Team members recorded ongoing checks associated with the date checking tasks they completed. And they kept a list of stock with short expiry dates. A random check of dispensary stock found no out-of-date medicines. The pharmacy had appropriate medicine waste receptacles and sharps bins available. 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.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

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

Inspector's evidence

The pharmacy had written reference resources available. And team members could access the internet to help resolve queries and to obtain up-to-date information. The pharmacy's computer was password protected. And information displayed on computer monitors could only be viewed by authorised personnel. The pharmacy stored bags of assembled medicines in boxes behind the medicine counter. The arrangement prevented personal 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. This included crown stamped measuring cylinders for use when measuring liquids and equipment for counting and cutting tablets. The consultation room was equipped to support the delivery of the vaccination service. And equipment was from recognised manufacturers. Electrical equipment was in good working order with electrical leads free of visual wear and tear.

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.