General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Weldricks Pharmacy, The Heathfield Centre, Ash Hill Road, Hatfield, DONCASTER, South Yorkshire, DN7 6JH

Pharmacy reference: 1093360

Type of pharmacy: Community

Date of inspection: 06/08/2024

Pharmacy context

The pharmacy is in a busy health centre in the town of Hatfield, close to Doncaster in South Yorkshire. Its main services are dispensing prescriptions, selling over-the-counter medicines and providing an NHS blood pressure check service to people. The pharmacy provides a range of other consultation services including the NHS England Pharmacy First Service, NHS New Medicine Service, and a private ear care service. The pharmacy supplies some medicines in multi-compartment compliance packs, designed to help people remember to take their medicines.

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	1.2	Good practice	The pharmacy uses ongoing monitoring processes effectively to share learning and to help reduce risk. Its team members act openly and honestly by engaging in regular reviews following the mistakes they make during the dispensing process. And they keep improvement actions under review to ensure they remain effective.
2. Staff	Standards met	2.2	Good practice	Team members are supported in completing continual learning both relevant to their role and to their career progression. They clearly demonstrate how they use the knowledge they gain to support them in delivering the pharmacy's services safely.
3. Premises	Standards met	N/A	N/A	N/A
4. Services, including medicines management	Standards met	4.1	Good practice	The pharmacy fully embraces providing person-centred care. It works effectively with other healthcare providers to ensure people can access the support and treatment they require in safe and timely manner.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance ✔ Standards met

Summary findings

The pharmacy effectively identifies and manages the risks to its services. It uses a range of ongoing checks to ensure it is providing its services safely. Its team members are committed to using learning to help them identify and reduce risk. And they keep the actions the take under review to ensure they remain effective. Pharmacy team members use feedback from people visiting the pharmacy to inform how they work. They work with care to help protect people's confidential information. And they have the knowledge and skills to recognise and report safeguarding concerns to help keep vulnerable people safe from harm.

Inspector's evidence

The pharmacy had standard operating procedures (SOPs) to support its safe and effective running. Its superintendent pharmacist's team reviewed most of the SOPs on a rolling two-year cycle. But some SOPs, such as the responsible pharmacist (RP) SOP were overdue for review. Team members accessed digital copies of the SOPs and they were notified of changes to existing SOPs and new SOPs by email. They completed training records confirming they had read and understood them. There was a monitoring process to ensure the pharmacy manager was notified of any overdue learning required.

The pharmacy's roles and responsibilities SOP was available in the dispensary for team members to refer to. Team members were observed following SOPs when completing dispensing tasks. A dispenser working in an accuracy checking role explained how pharmacists physically marked prescriptions to confirm a clinical check had taken place before accuracy checking dispensing assistants (ACDAs) completed an accuracy check of a medicine. A rota identified which team was the dispensary lead each day. This role involved leading the safe running of the dispensary and supported team members in completing a range of monitoring checks to help ensure the pharmacy was running safely and effectively. The team also undertook a series of weekly tasks to help ensure workload was up to date across all of the pharmacy's services. The pharmacy was subject to a series of internal audits. The team took the opportunity to discuss the performance of a recent audit designed to ensure it was operating safely and effectively.

Pharmacy team members were asked to review and correct their work when a mistake was identified during the dispensing process, known as a near miss. Team members recorded their own mistakes on a digital reporting system, this provided them with the opportunity to reflect on contributory factors and learning. And if they were not present when a near miss which involved them was identified, there was a process to inform them on returning to work. Near miss reporting was seen to be consistent with efforts made by team members to record their mistakes. The pharmacy had processes for reporting and learning from mistakes identified following the supply of a medicine to a person, known as dispensing incidents. The RP was a regular locum pharmacist, they discussed the steps they would take to respond to and report a dispensing incident. The pharmacy technician was the pharmacy's clinical governance lead. They led monthly patient safety reviews with the team which identified trends in mistakes and provided shared learning opportunities to help reduce risk. The team shared examples of how it acted to reduce risk following these reviews. For example, slowing down during the dispensing process to help reduce quantity errors, and highlighting liquid medicines that looked alike and sounded similar on the dispensary shelves. And the team kept the actions it took under review to help ensure they were

effective. A team member reflected on personal learning they completed following a dispensing incident. This had included refreshing their information governance learning.

The pharmacy had a complaints procedure. It advertised how people could provide feedback or raise a concern on its webpage on the company's website. But it did not advertise this process within the pharmacy. A team member explained how they would respond to feedback and concerns and how they would escalate these concerns to the attention of the pharmacy manager. The manager reflected on how a recent concern had supported the team in sharing learning about the importance of communication with people when a service could not be provided. The pharmacy had a safeguarding procedure and information was available to support its team members in raising safeguarding concerns with local safeguarding teams. Team members engaged in mandatory safeguarding learning. They provided examples of how they raised concerns with a GP surgery when they had concerns about a person's wellbeing. And they made checks to ensure people who visited the pharmacy frequently were safe and well when they had not been in. The pharmacy advertised its consultation room as a safe space for people. And team members knew how to support people requiring access to this safe space.

The pharmacy held all personal identifiable information in the staff-only area of the premises and on password protected computers. The pharmacy disposed of its confidential waste securely. It had a half-height partition wall at the front of the dispensary. People visiting the pharmacy were seen approaching the wall and leaning on it when speaking to team members. Team members were vigilant to the risk of this arrangement as people standing at the wall could potentially see the dispensary workspace, including prescription forms on the front workbench in the dispensary. The manager explained the issue had been raised with the company's maintenance team.

The pharmacy had details of its current indemnity insurance cover displayed. The RP notice displayed had the correct details of the RP on duty. A sample of pharmacy records found them to be mostly in order. But some pharmacists did not always sign out of the RP record and some details of prescribers were not always recorded accurately in the pharmacy's private prescription register. The pharmacy kept its controlled drug (CD) register electronically. It maintained running balances in the register, and it completed frequent checks of physical stock against running balances in the register. Random physical balance checks conducted during the inspection matched the running balances in the register. The team recorded patient-returned CDs in a separate section of the CD register at the point of receipt.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy employs a dedicated team of people with the right knowledge and skills to safely deliver its services. Team members have a positive attitude and work together well. They engage in reviews designed to support their learning and development. And they show how they apply the knowledge they gain from engaging in continual learning to support safe and effective care. Pharmacy team members take regular opportunities to share learning and to reduce risk through regular communication. They are confident in providing feedback and know how to raise concerns at work.

Inspector's evidence

The RP was working alongside the pharmacy manager, two ACDAs, a pharmacy technician and a dispenser as the inspection began. The pharmacy manager was a qualified dispenser, they were currently supporting another pharmacy through a temporary working arrangement which saw them managing both pharmacies. They explained how the working arrangement supported them in developing their management skills. The pharmacy also employed two other qualified dispensers and a trainee pharmacy assistant. It did not have a full-time regular pharmacist. A regular company-employed relief pharmacist worked one day a week. Either relief pharmacists or locums covered the remaining days. Team members worked flexibly to cover planned and unplanned leave and the pharmacy could request support from the local relief team if needed. Workload on the day of inspection was generally up to date. The team explained it was a little behind with dispensing activity due to two team members being on holiday. But its dispensing time was well within the timescales advertised to people.

Pharmacy team members received ongoing support and some training time at work for learning. The manager monitored ongoing e-learning relevant to team member's roles. And they contacted the company's training team if they identified areas where extra support might be required. All team members engaged in a structured appraisal process to help support their learning and development. They demonstrated how they used continual learning to support them in providing a person-centred approach when delivering pharmacy services. For example, by taking the time to discuss people's general health and lifestyle habits when providing blood pressure checks to help identify any changes people could make to support their long-term health. Team members providing the ear care service had completed e-learning, face-to-face training, and practical assessments prior to providing the service. The RP reflected on the support they had personally received from these team members in increasing their own confidence in their otoscope skills. The pharmacy had some targets for the services it provided. Team members had no concerns about these targets and the RP felt fully able to apply their professional judgement when working.

Pharmacy team members engaged in ongoing discussions to support workload management throughout the working day. They also shared information with each other, their managers, and peers through a secure messaging application. They used weekly huddles and formal monthly patient safety reviews to help share learning and monitor the actions they took to reduce risk. They also shared learning published by the superintendent pharmacist's team which focussed on safety information and changes to processes. The pharmacy had a whistleblowing policy and its team members understood how to provide feedback and raise concerns at work. A team member explained how they could escalate a concern if required and stated they would feel confident in doing so.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises offer a professional environment for delivering healthcare services. They are clean, secure, and appropriately maintained. People visiting the pharmacy can speak to team members in confidence in a private consultation room.

Inspector's evidence

The pharmacy was secure, it was clean and maintained to a good standard. Team members knew how to report maintenance concerns and there were no outstanding maintenance issues reported. Lighting was sufficient throughout the premises and air conditioning effectively controlled temperature throughout the premises. Pharmacy team members had access to sinks equipped with handwashing supplies and hand sanitiser was available for use.

The premises consisted of a large open plan public area leading to a medicine counter. The dispensary was behind a half-height wall beyond the medicine counter. The dispensary was an appropriate size for the level of activity carried out and workflow was managed safely. Workbenches were free of clutter and floors were free from trip and fall hazards. Staff facilities were available in rooms off the back of the dispensary. The pharmacy's consultation room was accessible to all. It was clean and professional in appearance. Team members were observed using the room with people when providing consultation services.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy is committed to making its services accessible to all. Its services are aligned well to the needs of the local community. Its team members work effectively with other healthcare providers to support people in accessing timely and effective care to help them stay healthy. The pharmacy obtains its medicines from reputable sources. And it stores them safely and securely. Pharmacy team members make regular checks to ensure medicines are safe to supply. And they provide people with relevant information to help people take their medicines safely.

Inspector's evidence

People accessed the pharmacy from either the onsite carpark or from an entrance leading from the health centre. The pharmacy advertised its opening hours on its door. Information about its services were advertised in its public area. The team was passionate about delivering pharmacy services. Information to support team members in delivering services safely was readily available to them. For example, service specifications, patient group directions and clinical pathways for the Pharmacy First service. Team members made records of the consultations they had with people. These records supported them in liaising with GP surgery teams if further intervention or treatment was required. Team members provided examples of people benefitting from this working arrangement. For example, the blood pressure check service had led to people being referred to their GP and commencing treatment for previously undiagnosed high blood pressure. The team explained how it then offered the New Medicine service (NMS) to these people to support them in taking their medicines safely. Pharmacists provided supporting information and answered any questions people had about their medicine when completing NMS consultations. Due to the popularity of the blood pressure check service the team had devised a calendar to support it in managing the fitting and loan of its ambulatory blood pressure machine to people requiring 24-hour continuous monitoring to support diagnosis.

Team members accessed remote support from audiologists and ear, nose, and throat specialists to support them in delivering the ear care service safely. The team was able to share images and videos of people’s ears securely through a cloud-based platform with the remote team when advice was needed. A team member provided examples of how this supported the team in speaking with people’s GPs to arrange referrals to secondary care when required. Team members gave examples where they had identified potential ear infections. And they had provided detailed information to the person's GP to allow them to assess if treatment was required.

The pharmacy protected Pharmacy (P) medicines from self-selection as it displayed these behind plastic screens on a wall close to the medicine counter. Signage informed people that staff assistance was required when selecting a medicine from behind the screens. Team members were observed making relevant checks to ensure P medicines were suitable for people to take. A team member discussed the vigilance they applied when managing requests for higher-risk P medicines liable to abuse. And they knew to refer concerns about repeat requests of these medicines to the RP.

The pharmacy had a process for identifying and managing higher-risk medicines during the dispensing process. A team member explained how this process helped to provide counselling and monitoring checks when supplying these medicines. And there was a range of support tools available to help

people take their medicines safely such as steroid cards and steroid emergency cards. Team members did not always record the interventions they made when handing out medicines on people's patient medication record (PMR) to support continual care. Team members understood the requirements of the valproate Pregnancy Prevention Programme (PPP) and they had a resource pack available to support them in supplying valproate safely. The RP discussed the checks they made when supplying valproate to people in the at-risk group. Some team members were aware of the topiramate PPP, but not all of the available resources to support the team in complying with this PPP were available to them.

The team used coloured baskets throughout the dispensing process. This kept medicines with the correct prescription form, and it helped inform dispensing priority. Pharmacy team members mostly took ownership of their work by completing dispensing audit trails on prescription forms to show who had received the prescription, generated dispensing labels, assembled the medicines and accuracy checked them. But locum pharmacists did not always engage in this process when completing the accuracy check of a medicines. All team members completed the 'dispensed by' and 'checked by' boxes on medicine labels. The pharmacy supplied a small number of medicines in multi-compartment compliance packs. It used individual record sheets to support it in making a series of checks when receiving prescriptions to identify any changes. It queried these changes with GP surgery teams by telephone. Team members annotated the records to show details of the change and when it had been applied. But they did not record the checks they made when confirming these changes. There were no assembled multi-compartment compliance packs available for inspection. A team member discussed how the packs were supplied, this process included writing descriptions beneath dispensing labels attached to the packs. The frequency of supplying patient information leaflets for the medicines inside a compliance pack varied. Some people received these at the beginning of four-week cycle, others only received them around every six months. A discussion reminded the team of the need to supply these leaflets routinely. The pharmacy carefully monitored the medicines it owed to people to help it in supplying these in a timely manner. Team members used the original prescription when dispensing owed medicines. Team members accessed an electronic system to track the delivery of medicines to people through the company's medicine delivery service.

The pharmacy had an automated dispensing robot that assisted the team by picking medicines for dispensing once a prescription was labelled. Team members understood the need for accuracy when entering prescription data to ensure the correct medication was selected within the robot. The team picked some larger bulk medicines and medicines stored in bottles manually. A team member explained that there was an ability to create a manual barcode for a medicine if the machine did not recognise the manufacturer's pack. This assigned a barcode to a specific product. They discussed the checks they made when following this process to assure themselves the correct details of the medicine was assigned to the barcode.

The pharmacy sourced medicines from licensed wholesalers and specials manufacturers. It stored the majority of its medicines inside the robot. A team member demonstrated how they safely loaded medicines into the machine and how they undertook regular checks of the medicines inside the machine to identify those with short dates. The team paid particular care when entering split boxes of medicines into the machine to ensure it provided the machine with accurate information about the quantity being entered. The pharmacy held its CDs in secure cabinets and storage inside the cabinets was orderly. There was designated space for storing patient-returned and out-of-date CDs within a cabinet. The pharmacy kept medicines requiring cold storage in an orderly manner inside medical fridges equipped with thermometers and data loggers. It kept temperature records for the fridges which showed they were mostly operating within the required range of two and eight degrees Celsius. Team members clearly documented details of additional checks they made if a temperature fluctuation

outside of the required range occurred.

Team members kept records of the stock checks they carried out, including date checking task. They recorded the opening date on bottles of liquid medicines to support them in ensuring the medicine inside remained safe to supply. A random check of dispensary stock found no date expired medicines. The pharmacy had appropriate medicine waste bins and CD denaturing kits to support it in disposing of medicine waste. It held unsealed waste bins safely. It received medicine alerts from the company's buying team, and it kept an audit trail of the action it took in response to these alerts.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs to provide its services. It makes regular checks to ensure its equipment is in safe working order. And its team members use the equipment in a way which protects people's confidentiality.

Inspector's evidence

The team had access to a range of reference resources, it accessed most of these digitally through the internet. The pharmacy protected its computers from unauthorised access through the use of passwords and NHS smart cards. Computer monitors in the dispensary were positioned facing into the dispensary which suitably protected information displayed on them. The computer and smart device in the consultation room were kept locked between use. The pharmacy stored bags of assembled medicines safely in boxes within the dispensary. This meant details on bag labels and prescription forms could not be read from the public area.

Pharmacy team members used cordless telephone handsets to support them in maintaining people's confidentiality when speaking to them on the telephone. The pharmacy team used standardised equipment for counting and measuring medicines. It clearly marked and stored equipment for counting and measuring higher-risk medicines separately. The pharmacy had maintenance support arrangements for its dispensing robot. Equipment was readily available to support the team in delivering the pharmacy's consultation services. This was routinely checked and cleaned between use. Single-use equipment such as earpieces for the otoscope was readily available. The pharmacy's electrical equipment was annotated to show it was regularly checked to ensure it was in safe working order.

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.