General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Weldricks Pharmacy, The Martinwells Centre, Thompson Avenue, Edlington, DONCASTER, South Yorkshire, DN12 1JD

Pharmacy reference: 1093361

Type of pharmacy: Community

Date of inspection: 15/02/2024

Pharmacy context

The pharmacy is in a purpose-built community centre where people access a range of NHS services and the town's public library. The pharmacy's main services are dispensing prescriptions, selling over-the-counter medicines, and providing support and advice to people with minor ailments.

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	1.8	Good practice	The pharmacy prominently advertises use of a safe space to people. Its team members are vigilant in identifying vulnerable people when carrying out their roles. And they work well with other healthcare professionals and agencies to help keep people from harm.
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 identifies and manages the risks for the services it provides effectively. It keeps people's confidential information secure, and it generally keeps the records required by law in order. The pharmacy team is particularly responsive in identifying and supporting vulnerable people. And team members work effectively with other healthcare providers to help keep people safe from harm. Pharmacy team members act on the feedback they receive about the pharmacy. They behave openly and honestly by sharing information when they make mistakes during the dispensing process. And they make changes to their practice to improve patient safety.

Inspector's evidence

The pharmacy had a comprehensive range of standard operating procedures (SOPs) to support its safe and effective running. Its superintendent pharmacist's team reviewed these periodically on a rolling two-year cycle and introduced new SOPs when services changed. Training records showed pharmacy team members had completed learning for the SOPs relevant to their role. And team members were observed working effectively within their roles when delivering the pharmacy's services. The pharmacy had a defined process for assessing skills and competencies which allowed its team members to take on additional roles to support the safe and effective running of the pharmacy. For example, most team members had completed relevant learning to allow them to undertake balance checks of controlled drugs (CDs) under the supervision of a pharmacist. The responsible pharmacist (RP) was a locum who was working their first shift at the pharmacy. They explained the checks the company carried out to ensure locums had read and understood the SOPs before they worked in their pharmacies.

Pharmacy team members reflected on mistakes made and identified during the dispensing process, known widely across the pharmacy sector as near misses. The team called these mistakes 'good catches' and recorded them on an electronic patient safety tool. They identified contributory factors as part of this recording process. The RP explained how they would respond to a mistake identified following the supply of a medicine to a person, known as a dispensing incident. And the pharmacy manager discussed their role in supporting reporting processes and next steps following a dispensing incident. Incident reporting showed reflection and learning following an adverse event. And included anonymised reporting of the mistake to the NHS 'Learn from Patient Safety Events' portal to inform wider learning across the healthcare sector. The pharmacy had a clear process for reporting mistakes involving CDs to the NHS CD accountable officer as required. But it did not always take the opportunity to report adverse events which required balance adjustments of a higher-risk medicine within its CD register when minor spills occurred. An accuracy checking dispensing assistant (ACDA) was the pharmacy's clinical governance lead and they engaged all team members in monthly clinical governance meetings. A team member shared an example of recent learning from this meeting which encouraged the team to work at a sensible pace when under pressure to help reduce risk.

The pharmacy had a complaints procedure. And its team members knew how to manage feedback and how to escalate a concern when required. The team regularly discussed feedback from reviews left about the pharmacy on the internet. And it used a notes function on the patient medication record (PMR) to support team members in meeting people's individual needs following feedback. Team members engaged in mandatory learning on confidentiality and team members understood the importance of keeping people's information safe and secure. The pharmacy held all personal identifiable information in the staff-only area of the premises. Confidential waste was segregated and

securely disposed of. The pharmacy advertised its privacy policy and its chaperone policy to people.

The team engaged in safeguarding learning to help protect vulnerable people. They had a good understanding of how to recognise and report safeguarding concerns, including the need to inform the RP of any concerns they had. And they had contact information for local safeguarding agencies and key workers. Observations during the inspection showed team members clearly put the needs of vulnerable people first. And they worked together with the RP and with other healthcare professionals when doing this. Team members took opportunities to share concerns and record information to support them in keeping people safe. The pharmacy prominently advertised use of a safe space to people experiencing domestic violence. And it advertised harm reduction information for people attending for substance misuse services. A team member discussed the steps they would take if people requested use of the safe space or used code phrases promoted by domestic violence safety initiatives.

The pharmacy had current indemnity insurance. The RP notice on display was changed as the inspection began to reflect the correct details of the RP on duty. Most pharmacy records examined were maintained as required. But there were two recent gaps in the RP register and RPs did not always sign-out of the register at the end of the working day. Some private prescription and veterinary prescription records were not made with accurate details of the prescriber. The pharmacy maintained running balances in its CD register and completed frequent full balance checks of physical stock against the register. A random physical balance check of CDs conducted during the inspection complied with the running balances in the register. The team recorded patient-returned CDs in a separate register at the point of receipt.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough skilled and knowledgeable people working to provide its services safely and effectively. It uses structured processes to support the learning and development of its team members. Pharmacy team members engage in regular conversations about patient safety and risk management. They work together well and are confident in providing feedback at work.

Inspector's evidence

The pharmacy manager was a qualified dispenser and was working alongside the RP, another qualified dispenser, and a trainee dispenser. The manager explained the team were short-staffed due to both planned and unplanned absence. They had reached out to their area manager about the situation and during the inspection both the area manager and the company's pharmacy support coordinator, both qualified dispensers, attended to support the team. They integrated themselves into the team immediately. The pharmacy also employed an ACDA, three qualified dispensers, a trainee dispenser, and a trainee medicine counter assistant. It was advertising for a regular pharmacist to join the team and a new team member was due to start their induction training shortly. Team members worked flexibly to cover leave and the pharmacy requested support from the area relief team if needed. The pharmacy was busy throughout the inspection and all team members worked well together to provide a safe and efficient service. The team was generally up to date with its workload. Team members discussed some workload pressures due to recent absence and vacancies.

Pharmacy team members received time to support them in completing regular learning relevant to their roles. This included both mandatory e-learning and learning to support the team in delivering pharmacy services confidently and safely. Team members benefited from regular one-to-ones with their manager, and they engaged in a formal appraisal process to support their learning and development. The pharmacy had some targets for the team to meet. Team members did not feel pressurised by these targets and the RP was clearly able to apply their professional judgement when delivering pharmacy services. Pharmacy team members engaged in structured clinical governance meetings each month and recorded key learning points from these discussions. They read the company's weekly newsletters to help keep themselves informed about changes to services and planned events, such as updates to the PMR system. And they engaged in regular informal day-to-day briefings to support them in managing workload. The pharmacy had a whistle blowing policy and its team members understood how they could raise and escalate a concern at work, including in confidence. The pharmacy encouraged its team members to feedback. And a team member explained how the team trialled changes to processes and reviewed them before making them permanent.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are clean, tidy, and secure. They offer a professional environment for delivering healthcare services. People using the pharmacy are able to speak to a member of the pharmacy team in a private consultation room.

Inspector's evidence

The pharmacy was secure and maintained to a good standard. It was organised and clean. The owners carried out periodic assessments of the pharmacy to ensure the premises remained safe. The team understood how to report maintenance concerns and there were no outstanding maintenance issues waiting to be resolved. Lighting was bright throughout the premises. And heating and ventilation arrangements were appropriate with air conditioning provided.

The public area of the pharmacy was open plan with a designated seating area for people to wait. The pharmacy had two private consultation areas leading off the public area. People accessed one area through a door to the side of the pharmacy's entrance, this led to a room with a hatch into the dispensary. The second area was a small consultation room to the side of the medicine counter. The room was clean and professional in appearance. The dispensary was clean and orderly. The pharmacy used a robot to support dispensing tasks and the team used workspace well with individual dispensing stations linked to the robots output chutes providing protected space for dispensing tasks. Both the pharmacist and ACDA had appropriate space at individual workstations to complete the final accuracy check of medicines safely. Rooms leading from the back of the dispensary provided staff facilities.

Principle 4 - Services ✔ Standards met

Summary findings

Overall, the pharmacy's services are accessible to people. The pharmacy obtains its medicines from reputable sources, and it stores them safely and securely. Pharmacy team members provide relevant information to people to help them take their medicines safely. And they engage well with people by taking opportunities to talk to them about their health and the medicines they are taking.

Inspector's evidence

People accessed the pharmacy either through a wide entrance leading from the community centre or from doors at street level leading from the carpark. The pharmacy advertised its opening hours and information about the services it provided. It protected Pharmacy (P) medicines from self-selection by displaying these behind transparent plastic screens in the public area. There was signage advising people to seek the assistance of team members when requesting a P medicine. And team members were observed supporting people who requested these medicines. Team members understood the risk of misuse of some P medicines, and they explained how they brought repeat requests to the attention of the RP. They provided examples of repeat sales being refused with people signposted appropriately to their GP.

Most pharmacy services were fully accessible to people with information readily available to support team members in delivering these services. This information included current patient group directions (PGDs) to support the legal supply of prescription-only medicines through some of its services. The RP discussed the learning they had carried out to safely provide the Pharmacy First service and they were familiar with the PGDs. Team members knew how to signpost people to other pharmacies and healthcare services in the event a service could not be provided. And they informed people of access arrangements, such as lunch time closures. The pharmacy's needle syringe provision service was currently only available when the pharmacy manager was on duty which did limit access to this service.

The team used a range of tools to support monitoring checks for higher-risk medicines. This included regular 'therapy checks' on a range of medicines including opioids, warfarin, lithium, and methotrexate. Team members recorded these checks. A team member discussed the dispensing requirements related to the valproate pregnancy prevention programme (PPP), including ensuring the necessary safety information was included when supplying valproate to people. The RP had a good understanding of the safety checks required as part of the PPP. There was a range of tools available to support counselling when supplying higher-risk medicines to people. The RP was observed counselling people on the safe use of their medicines when handing them out. And they worked well with team members by taking the opportunity to speak to people when a query about their health or medicine occurred.

Pharmacy team members transcribed information from prescriptions to the pharmacy's automated dispensing machine to support the safe supply of substance misuse medicines. The data accuracy of this information was checked by a pharmacist prior to supplies of medicines commencing. The team kept robust records of the substance misuse medicines it dispensed. This allowed team members to identify gaps in treatment and report these through to the substance misuse team effectively. Pharmacy team members used baskets throughout the dispensing process to help keep all items for each prescription together and to help identify workload priority. They took ownership of their work by applying their

initials to medicine labels and through completing an audit grid on prescription forms. This was designed to identify who was involved at each stage of the dispensing process. But a sample of dispensed prescriptions identified pharmacists did not always complete their parts of the prescription audit trail to show who had clinically checked and accuracy checked a medicine. The pharmacy kept clear records and audit trails of any medicines it owed to people. And its team members referred to the original prescription when later supplying owed medicines.

The pharmacy sourced medicines from licensed wholesalers and specials manufacturers. It generally stored medicines in an orderly manner within their original packaging. There were several containers containing split packets of medicines waiting to be manually loaded into the robot. This did increase the manual input into the dispensing process and the risk of human-error. Team members were observed picking medicines from these boxes to fill prescriptions on several occasions during the inspection. The pharmacy held its CDs in legally compliant cabinets. And it held medicines requiring cold storage in medical fridges equipped with thermometers and date loggers. It kept temperature records for the fridges which showed they were operating within the required range of two and eight degrees Celsius. Pharmacy team members carried out regular checks of medicines. And a team member demonstrated how the team recorded details of shorter expiry dates when entering medicines into the robot. This supported the team in managing its date checking tasks effectively. The team kept records of the date checks it completed. A random check of dispensary stock found no out-of-date medicine. Team members annotated bottles of liquid medicines with both the date of opening and the medicines shortened-expiry date where appropriate. This prompted checks to ensure any medicine in a bottle remained safe to dispense. The pharmacy had appropriate medicine waste receptacles. The team received medicine alerts electronically and kept a record of the checks it made in response to these alerts.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs for providing its services. And it maintains its equipment appropriately. Its team members use the equipment and facilities in a way which protects people's confidentiality.

Inspector's evidence

Pharmacy team members had access to the internet and a range of electronic reference resources. They used passwords and NHS smart cards when accessing people's medication records. The team stored bags of assembled medicines safely within the dispensary. This prevented people's personal information on bag labels and prescriptions from unauthorised view. The pharmacy used a cordless telephone handset. This allowed team members to step away from the public area and dispensary hatch to protect people's personal information when speaking to them on the telephone.

The pharmacy had a range of equipment to support it in delivering its services including a range of appropriate clean counting triangles and CE marked measuring cylinders. The pharmacy had clearly labelled equipment its team members used when counting and measuring higher-risk medicines. Equipment to support the delivery of consultation services was from recognised manufacturers and this was stored appropriately. The pharmacy had a service contract for its robot and automated dispensing machine. Trouble shooting information for the robot was available as well as remote support. And the pharmacy manager reported timely resolution of issues. The team completed calibration checks of the automated dispensing machine daily.

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.