General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Blidworth Pharmacy, 57 Mansfield Road, Blidworth, MANSFIELD, Nottinghamshire, NG21 0RB

Pharmacy reference: 1094641

Type of pharmacy: Community

Date of inspection: 07/03/2024

Pharmacy context

This pharmacy is on a main road in the Nottinghamshire village of Blidworth. Its main services include dispensing NHS prescriptions, selling over-the-counter medicines and providing advice and treatment for people with minor illnesses. The pharmacy provides the NHS Pharmacy Contraception Service and NHS Hypertension Case-Finding Service. It supplies some medicines in multi-compartment compliance packs, designed to help people remember to take their medicines. And it dispenses medicines for people living in local care homes. The pharmacy offers a medicine delivery service 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	1.2	Good practice	Pharmacy team members engage well in processes designed to reduce risk following the mistakes they make during the dispensing process. They show how they reflect on their own practice and they actively participate in structured conversations to support them in identifying and monitoring risk.
		1.4	Good practice	The pharmacy actively encourages people to feedback about their experiences. And its team uses the feedback it receives to share learning and to inform change.
		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 keep records of the concerns they have. And they work well with other healthcare professionals to support people in taking their medicines safely.
2. Staff	Good practice	2.1	Good practice	The pharmacy has continuous processes to effectively monitor its workload, staffing levels and skill mix. It plans its workload well to ensure workload pressure does not impact on the safety of its services during busy periods and during periods of staff absence.
		2.4	Good practice	Pharmacy team members are committed in their roles. They enthusiastically engage in structured learning and conversations designed to manage risk. And they show how they use their learning to inform the way they provide pharmacy services.
		2.5	Good practice	The pharmacy actively encourages feedback from its team members. It uses this feedback to inform the way it provides its services. And it ensures team members know how to access the company's confidential support services designed to support their wellbeing.
3. Premises	Standards met	N/A	N/A	N/A

Principle	Principle finding	Exception standard reference	Notable practice	Why
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 has a robust approach to identifying and managing risk, particularly when implementing new services. It encourages people to provide feedback about their experiences. And it uses this feedback to inform effective change. Pharmacy team members act with care to reduce risk following the mistakes they make during the dispensing process. And they keep these actions under review by engaging in regular and comprehensive patient safety reviews. Pharmacy team members are committed to protecting vulnerable people to keep them safe from harm. And they work with other healthcare professionals to support people in taking their medicines safely. Pharmacy team members adequately protect people's confidential information. And they mostly make the records they need to by law.

Inspector's evidence

The pharmacy had standard operating procedures (SOPs) designed to support its safe and effective running. Team members had signed the SOPs to support them in conducting tasks safely. Team members had a good understanding of their roles and recognised when they required support or needed to refer to the responsible pharmacist (RP). For example, a team member discussed the tasks they could not complete if the RP took absence. There was an audit trail to support the pharmacy's accuracy checking pharmacy technician (ACPT) in their role. The RP recorded clinical checks on prescription forms ahead of the ACPT completing an accuracy check of a medicine. The pharmacy had a business continuity plan and team members were familiar with how to access this. It identified risks and prepared well when planning to introduce new services. For example, three team members were completing learning to support them in offering an ear care service. The team had identified how this would support people in accessing the services across the pharmacy's opening times. The team had looked at its current facilities for offering this service. In doing so, it had identified concerns with the size and layout of the consultation room. It had escalated these concerns. And as a result, the pharmacy's head office team was liaising with the ear car service provider about the space needed to safely provide this service.

Pharmacy team members engaged well in shared learning following the mistakes they made and identified during the dispensing process, known as near misses. And from the mistakes identified after a medicine was supplied to a person, known as dispensing incidents. Team members corrected their own mistakes whenever possible. There was a clear process for accuracy checkers to feedback to team members and to support them in reporting their own mistakes, including those identified when team members were not on duty. This approach supported team members in their personal learning. The RP had joined the pharmacy team in January 2024 as its regular pharmacist, they were familiar with the pharmacy's incident reporting process. The ACPT led a monthly patient safety review and all team members engaged in this review. They felt the suggestions they made during these reviews were listened to and implemented to help reduce risk. A team member discussed a particular focus on recognising patterns in near misses involving medicines that looked similar to others and those that sounded alike. And they demonstrated how the team acted to reduce risk by using baskets on stock shelves to separate medicines more likely to be involved in a mistake. The team regularly reviewed the actions it had taken to ensure they were working in practice. And team members felt empowered to suggest an alternative action if they felt current actions were not working.

The pharmacy had a complaints procedure, and it advertised details of how people could provide feedback. An interactive device at the medicine counter asked people to leave 'in the moment' feedback about the service they had received when visiting the pharmacy. The team used the feedback it received to reflect on current practices and to inform change. For example, it had identified the need to actively inform people the pharmacy had a private consultation room available for use following feedback about counselling completed at the medicine counter. All pharmacy team members engaged in learning to support them in identifying and reporting safeguarding concerns, the RP had completed level three safeguarding learning. The team had safeguarding procedures, safeguarding pathways and contact information for safeguarding teams readily available to refer to. Team members understood their responsibilities in keeping people safe from harm. They documented their concerns when reporting them. And they demonstrated how they worked effectively with other healthcare professionals to support vulnerable people in receiving their medicines safely. The pharmacy advertised how people suffering from domestic abuse could access support, including use of the pharmacy's safe space. A team member described how they would support a person presenting at the pharmacy requesting use of its safe space.

The pharmacy was registered with the Information Commissioner's Office. It had procedures to support its team members in managing confidential information. And it had secure arrangements for separating and disposing of its confidential waste. The pharmacy had current indemnity insurance. The RP notice displayed the correct details of the RP on duty. A sample of pharmacy records found them to be mostly completed in accordance with regulatory and legal requirements. There were several sign-out times missing in the RP register, team members did not always record the wholesaler addresses when entering a controlled drug (CD) into the CD register, and on occasion the prescriber's details recorded in the private prescription register did not match the details on the private prescription. The pharmacy kept running balances within its CD register. And it conducted regular physical balance checks of its CDs against balances in the register. A random physical balance check of a medicine conformed to the balance recorded in the CD register. The pharmacy had a register to records its patient-returned CDs, but it did not record returns upon receipt. A discussion took place about the need to record patient-returned CDs at the point of receipt. And the pharmacy manager provided confirmation that the team had acted to record and safely destroy the patient returns in the CD cabinet shortly after the inspection.

Principle 2 - Staffing ✔ Good practice

Summary findings

The pharmacy uses continuous processes to review its staffing levels and skill mix to ensure it can safely provide its services. It listens to feedback provided by its team members and uses this feedback to inform positive change. Pharmacy team members are happy in their roles, and they work together well. They clearly show how they apply the knowledge and skills they gain through continual learning to support them in delivering the pharmacy's services safely. Pharmacy team members engage in meaningful discussions about patient safety, and they act with care by reviewing any changes they make to ensure they remain effective.

Inspector's evidence

The RP was working alongside the pharmacy manager (a qualified dispenser), two other qualified dispensers, the ACPT, the MCA, a driver, and a pharmacy technician during the inspection. The pharmacy technician was a locum team member employed to support the team due to a staff member being absent from work. The pharmacy also employed two other dispensers. Another part-time driver supported the pharmacy's medicine delivery service. The pharmacy took a robust approach to managing its staffing rota. And demonstrated how this planning considered long-term absences within the team, the need to maintain service availability and reviewed the skills mix of team members on duty at any given time. It was currently planning workload ahead of some upcoming bank holidays. The pharmacy employed locum team members during periods of staff absence to ensure it could continue to provide its services safely. The locum pharmacy technician had worked four shifts in the pharmacy. They expressed that team members made them feel welcome and they felt comfortable sharing feedback with the team. The pharmacy had some targets for the services it provided. The manager and RP discussed the team's approach to managing these targets. The RP felt supported in their role and was clearly able to apply their professional judgment when working.

The pharmacy displayed certificates showing its team members qualifications to people using the pharmacy. And it kept training records of the learning its team members completed. The RP had completed a range of courses to support them in safely delivering the new NHS Pharmacy First service. All pharmacy team members engaged in continual training relevant to their roles. This included both mandatory and optional e-learning. Team members were able to complete learning at work or at home dependent upon their personal preference. And they demonstrated how they applied this learning in practice. For example, the RP discussed the information they provided when holding a contraception service consultation with a person, this information helped people to make an informed decision about the type of contraceptive pill that was right for them. And team members supported the Hypertension Case-Findings service by carrying out blood pressure checks after completing relevant learning. Team members were observed sharing learning during the inspection and this included discussing how they would apply the learning to practice.

Team members had begun to prepare for their appraisal with the manager. The pharmacy had a whistle blowing policy and team members were encouraged to share their ideas. They were confident in providing feedback at work. And they understood how to escalate a concern if needed. The pharmacy used feedback from its team members to inform the way it provided its services. For example, the team had introduced a system of referring queries and requests for services into the dispensary through a

paper-based slip system. This had effectively streamlined the management of requests and had reduced unnecessary conversations interrupting activity in the dispensary. The manager felt supported by the pharmacy's head office team. They were kept informed of planned changes to pharmacy services. And they effectively communicated updates about these changes to the wider team to support in managing the change effectively. The manager explained there had been a recent opportunity to remind team members of the availability of the company's confidential employee assistance programme.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean, secure, and maintained to an appropriate standard. People using the pharmacy can speak to a member of the team in a private consultation room.

Inspector's evidence

The pharmacy was secure and well maintained. Team members knew how to report maintenance concerns and there were no current maintenance issues. The pharmacy was clean and generally organised. Lighting was bright and air conditioning helped to provide an ambient temperature for delivering pharmacy services. Team members had access to sinks equipped with antibacterial hand wash and paper towels. Hand sanitiser was available in the pharmacy's consultation room. A sink in the consultation room was in working order but it was not easily accessible to team members due to the size and layout of the room.

The public area was fitted with wide-spaced aisles. Team members promoted the availability of the consultation room to people. And the RP used the room to speak with people throughout the inspection. Team members were able to monitor access into the room. The room was clean, but it was small and somewhat cluttered with equipment, including a filing cabinet. This distracted from the overall professional appearance. Access into the dispensary was from behind the medicine counter. The team used the available space in the dispensary well. It used protected space when assembling medicines in multi-compartment compliance packs, and it utilised shelves to hold baskets of medicines waiting to be checked. This practice promoted a safe working environment as work benches remained free of clutter. But storage space in the pharmacy was limited. And the team stored some items such as boxes of capped medicine bottles in the staff toilet. A discussion highlighted the need to review this storage arrangement.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's services are readily available to people. It obtains its medicines from reputable sources. And it stores its medicines safely and securely. Pharmacy team members demonstrate how they provide person-centred care when delivering the pharmacy's services. And they provide relevant information when supplying medicines, to help people take their medicines safely.

Inspector's evidence

People accessed the pharmacy through automatic doors at street level. The pharmacy advertised its opening times and details of its services for people to see. It aligned the health promotion material it displayed to the services it was providing and to the training the team had recently completed. For example, an informative display about ear care and hearing loss helped to support team members in using the knowledge they had gained during recent training when speaking to people about this topic. Pharmacy team members took regular opportunities to speak to people about their health and wellbeing. They appropriately referred people to other healthcare services when needed. The pharmacy stored Pharmacy (P) medicines behind the medicine counter. The RP had appropriate supervision over the medicine counter and public area. And team members had good knowledge of the risks associated with P medicines that were liable to abuse. They appropriately brought repeat requests for these medicines to the attention of the pharmacist. Pharmacists declined sales and referred people to their GP when they were not satisfied a repeat request was appropriate.

The pharmacy provided a range of consultation services, including consultations to support people accessing treatment and advice for minor illnesses and to access emergency hormonal contraception (EHC) and the contraceptive pill. The RP had supportive information readily available to them when delivering these services. This included service specifications, procedures, and signed Patient Group Directions (PGDs). The RP provided examples of the information they discussed with people during consultations. And they reflected on how this helped people to feel assured they were given the most appropriate treatment and advice for their symptoms. The ACPT took an active role in providing the NHS Discharge Medicine Service and they kept comprehensive audit trails of the steps they took to support people with changes to their medicine regimens when returning home from hospital. This included following up with GP surgery teams. This approach meant the RP was able to take over aspects of the service should the ACPT be on leave. Pharmacy team members understood the requirements of the valproate Pregnancy Prevention Programme (PPP), including the need to supply valproate in original containers. A team member discussed the checks they would make if there was a need to supply valproate to a person in the at-risk group. The team engaged in ongoing audits to support the safe supply of medicines to people. And team members provided counselling to people when handing out medicines. But they did not regularly take the opportunity to record these types of interventions on people's medication records to support continual care.

The pharmacy team used baskets throughout the dispensing process. This kept medicines with the correct prescription form and helped inform workload priority. It used effective audit trails to identify who had been involved in the dispensing process. And to support it in safely managing the medicines it owed to people and the medicines it delivered to people. The pharmacy managed the supply of medicines to people residing in care homes safely. It used effective audit trails, communication records

and medication administration records (MARs) to support the supply of medicines in this way. The pharmacy kept robust records for the medicines it supplied in multi-compartment compliance packs. The records included changes to people’s medicine regimens and the checks team members made when confirming these changes with prescribers. The pharmacy had recently started to complete assessments with people to ensure supplying them with their medicines in compliance packs was the safest and most suitable way of supply for them. Following this assessment some people had agreed to receive their medicines in original packs with some support from the pharmacy who continued to order their prescriptions for them. A sample of assembled compliance packs found them to be clearly labelled with descriptions of the medicines provided inside them recorded. The pharmacy provided patient information leaflets at the beginning of each four-week cycle.

The pharmacy obtained its medicines from licensed wholesalers, and it stored them tidily and within their original packaging. Team members explained they carried out checks of medicine's expiry dates. But the pharmacy’s date checking record was not available during the inspection. A random check of stock found no out-of-date medicines. The team marked liquid medicines with details of their opening dates to ensure they remained safe and fit to supply. The pharmacy kept CDs securely in cabinets. The team clearly identified out-of-date and patient-returned medicines within the cabinets. The pharmacy’s medicine fridge was nearing its storage capacity. The team monitored the operating range of the fridge daily and, records showed it was operating within the required temperature range of two and eight degrees Celsius. The pharmacy had appropriate medical waste receptacles to support the safe disposal of medicine waste. It received medicine alerts electronically and kept an audit trail of the actions it took 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. It monitors the equipment to ensure it remains safe to use. Pharmacy team members complete relevant training to ensure they operate the equipment safely. And they use the equipment in a way which protects people's confidentiality.

Inspector's evidence

Pharmacy team members used a range of clean standardised equipment for counting and measuring medicines. It clearly identified separate equipment for use when counting and measuring higher-risk medicines. Equipment to support the pharmacy's consultation services was readily available for use. And team members engaged in appropriate training that ensured they knew how to use this equipment safely and effectively. The pharmacy's electrical equipment was subject to periodic safety checks, the last recorded check was January 2023. The pharmacy stored bags of assembled medicines in the dispensary, out of the direct view of the public area. It protected information on its computer monitors from unauthorised view. Pharmacy team members used cordless telephone handsets when speaking to people on the telephone. This allowed them to protect the privacy of the call when discussing information with them. Pharmacy team members had access to appropriate reference resources as well as the internet. And they used NHS smartcards and passwords when accessing people's medication records.

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.