General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Nabbs Lane Pharmacy, 63 Nabbs Lane, Hucknall, NOTTINGHAM, Nottinghamshire, NG15 6NT

Pharmacy reference: 1095582

Type of pharmacy: Community

Date of inspection: 24/04/2023

Pharmacy context

The pharmacy is co-located with a Post Office on a housing estate on the outskirts of Hucknall in Nottinghamshire. Its main services include dispensing NHS prescriptions and selling over-the counter medicines. The pharmacy offers a medicine delivery service. It supplies some medicines in multi-compartment compliance packs, designed to help people remember to take their medicines. It also supplies medicines to people living in local care homes and supported living accommodation.

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 identifies and manages the risks associated with its services adequately. It keeps people's confidential information secure. And it uses feedback it receives to inform the way it delivers its services. The pharmacy mostly keeps the records required by law. Its team members understand how to recognise and respond to safeguarding concerns. And they engage in some conversations to help reduce risk following mistakes made during the dispensing process.

Inspector's evidence

The pharmacy held a range of standard operating procedures (SOPs) electronically. These covered the responsible pharmacist (RP) role, controlled drug (CD) management and pharmacy services. And they had been updated within the last year. Pharmacy team members had signed an associated training record to confirm they had read and understood the SOPs. A team member clearly explained what tasks could not be completed in the event the RP took absence from the pharmacy. Another team member was observed completing tasks in the dispensary in accordance with details within the SOPs. For example, creating owing slips to give to people informing them of any medicines owed to them. The pharmacy operated a COVID-19 vaccination service. It provided this service from associated premises on specific dates, and within the pharmacy on other dates. The service was provided by a COVID-19 team, led by the superintendent pharmacist (SI). The RP explained that paperwork associated with this service included specific guidance, SOPs and risk assessments was transferred between the two vaccination sites; the pharmacy was not providing the service on the day of inspection and as such this documentation was not available to view.

Pharmacy team members engaged in learning following mistakes made and found during the dispensing process, known as near misses. The team recorded some near misses on a record. Gaps in the record were most common during busy periods. For example, ahead of bank holidays. The pharmacy manager provided regular feedback to team members about their mistakes, and they led team discussions related to patient safety. The team demonstrated how it acted to reduce risk following mistakes. For example, it had separated different strengths of lansoprazole capsules on the dispensary shelves to reduce the risk of picking the wrong strength. The pharmacy had a procedure to support the team in reporting a mistake found following the supply of a medicine to a person, known as a dispensing incident. The RP described the process which included informing the SI of the mistake made and completing an incident report. There was no evidence of recent incident reporting available.

The pharmacy had a procedure for managing concerns. And its team members understood the importance of referring concerns to the RP to ensure people's expectations were met. The pharmacy had acted on feedback provided at the last inspection by making improvements to its services. For example, by physically attaching backing sheets to multi-compartment compliance packs when supplying medicines in this way. It had also acted on feedback provided by one of its home care providers by changing the way it provided medicines to people following feedback from the home care provider's own regulator. The pharmacy had procedures to support its team members in recognising and raising concerns about vulnerable people. Its team members shared examples of where they had raised a concern about a person's wellbeing with their surgery and this had been acted upon to keep the person safe. Pharmacy team members explained how they would respond to a situation where a

person attended the pharmacy seeking support through either the ‘Safe Spaces’ or ‘Ask for ANI’ safety initiatives, designed to protect those experiencing domestic violence.

The pharmacy displayed details of its current insurance arrangements. There were two RP notices displayed as the inspection begun. One notice was removed immediately, the remaining notice contained the correct details of the RP on duty. The pharmacy manager did not routinely sign-out of the RP record when completing their shift. And details of the prescriber were absent from the sample of the electronic Prescription Only Medicine (POM) register entries examined. A discussion highlighted the requirement to ensure records contained clear and accurate information. The pharmacy maintained most sections of its CD register electronically. It kept manual records associated with a commonly dispensed liquid formulation CD. But it did not always record page headers or wholesaler addresses within the manual register. The RP completed some balance checks of physical stock against the CD register. These varied in frequency and generally took place every one to three months. Physical balance checks of stock completed during the inspection identified one discrepancy which the RP quickly resolved. The pharmacy kept a record of patient-returned CDs. But the team did not always take the opportunity to record the receipt of a returned CD within the patient returned register at the point of receipt. A discussion set out the rationale of why this was required. The pharmacy kept full audit trails of the unlicensed medicines it dispensed. The pharmacy held confidential information within the staff only area. All team members understood the need to keep people’s personal information safe. And they disposed of confidential waste securely.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has suitably skilled and knowledgeable people working to provide its services safely and effectively. Pharmacy team members work together well, and they demonstrate enthusiasm for their roles. They engage in discussions and learning relevant to their role. And they understand how to raise concerns at work.

Inspector's evidence

The full-time pharmacist manager worked alongside two full-time qualified dispensers, a part-time qualified dispenser, a part-time medicine counter assistant, and a delivery driver. One of the full-time dispensers had been recruited since the last inspection of the pharmacy in August 2022. Having an additional team member supported the team in day-to-day workload and completion of key housekeeping tasks. Pharmacy team members were observed working together well and workload was up to date. Team members felt that workload pressure had decreased in recent months, and they appeared happy in their roles. The medicine counter assistant completed the majority of tasks associated with the Post Office business. All other team members contributed to covering both the medicine counter and Post Office counter when required. Recent changes to the owner's portfolio of pharmacies meant that there was additional support locally in the event that staffing levels were affected by unplanned absences.

Pharmacy team members received some ongoing support at work through an annual appraisal. And they were able to request one-to-one meetings with the SI if they had matters, they wanted to discuss between these formal meetings. Team members engaged in some ongoing learning associated with their roles. This had recently focussed on reading updated SOPs and completing some learning associated with the valproate Pregnancy Prevention Programme (PPP). A team member demonstrated key safety information they had learnt when supplying valproate to a person within the at-risk group. The RP discussed the pharmacy's targets in relation to providing services. And they demonstrated how they applied their professional judgment in the best interests of people accessing the pharmacy's services. The RP led regular discussions related to workload and patient safety. But the team did not take the opportunity to record details of these discussions to support it in reviewing agreed actions to ensure they remained effective. Pharmacy team members felt able to provide feedback at work. They knew how to escalate concerns at work if required.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are clean, secure, and appropriately maintained. People using the pharmacy can speak with a member of the pharmacy team in a private consultation room.

Inspector's evidence

The pharmacy was appropriately secure and maintained. It was clean and tidy. Pharmacy team members had access to handwashing facilities to support them in working hygienically. Air conditioning in the public area helped to maintain an appropriate room temperature. But plastic screening around the medicine and Post Office counter prevented the dispensary fully benefitting from the air conditioning. The screen was designed to protect team members in working safely. Pharmacy team members used fans in the dispensary during summer months and ventilation was appropriate. Lighting throughout the premises was sufficient. The pharmacy consisted of a mid-sized public area with direct access to the Post Office and medicine counter, these were situated together in front of the dispensary. A secured gate at the side of the medicine counter prevented unauthorised access past this point. To the side of the medicine counter was the pharmacy's consultation room, access into this room was controlled by team members. The room offered a suitable private space for delivering consultation-led services. And the RP was observed inviting people into the room when managing requests for advice. Pharmacy team members completed the majority of dispensing tasks in the main dispensary. A room off the dispensary acted as a mixed storeroom for the pharmacy and post office. It also provided some protected space for completing tasks associated with the multi-compartment compliance pack services. An area off this room provided access to staff facilities.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's services are accessible to people. It obtains its medicines from licensed sources. And it generally stores its medicines safely and securely. Pharmacy team members work effectively to manage the pharmacy's services. They recognise the benefits of engaging people in conversations about their health and the medicines they are taking. And they provide relevant information to support people in taking their medicines safely.

Inspector's evidence

People accessed the pharmacy up a small step from street level. There was a bell close to the door for people to seek assistance from the team with entry, and a portable ramp was available. The pharmacy advertised its services through professional looking window displays. People using the pharmacy had access to information about a range of health conditions through a prominent display in the public area and information leaflets that they could take away with them. Seating in the public area allowed people to wait in comfort. Pharmacy team members were observed supporting people with accessing healthcare services. For example, providing information about how to book a COVID-19 vaccination online or by telephone. In some circumstances the team provided support with the booking process. For example, when people did not have internet access.

The pharmacy protected Pharmacy (P) medicines from self-selection as it displayed them behind the medicine counter. And the RP had good supervision of the counter from the dispensary. The RP was observed providing counselling at the medicine counter when handing out bags of assembled medicines. And they made themselves available when a person requested to speak to the pharmacist. The RP reflected on positive comments received about taking the time to speak to people about the medicines they were taking through the NHS New Medicine Service. The pharmacy had some procedures to support its team members in identifying and managing higher risk medicines. The team had recently completed a valproate safety audit to ensure it complied with the requirements of the valproate PPP. In response to this audit the RP had made further checks with prescribers to ensure people within the at-risk group had a pregnancy prevention plan where indicated and had an up-to-date risk acknowledgement form. The team did not consistently record counselling interventions on patient medication records (PMRs) to support them in delivering continual care.

Pharmacy team members used baskets during the dispensing process to keep each person's prescription and medicines separate from others. The pharmacy team used effective audit trails throughout the dispensing process to help identify who had completed tasks associated with dispensing prescriptions. It also kept a record of the medicines people ordered when submitting prescription requests to surgeries on people's behalf. This supported the team in raising queries and contacting the surgery for missing prescriptions when required. The pharmacy's delivery driver posted a card informing people of a missed delivery if they were not at home, and medicines which could not be delivered were returned to the pharmacy. The driver returned paperwork to the pharmacy following their delivery run. This contained an audit trail of the deliveries made. A phone call during the inspection highlighted a need for the team to keep a copy of the delivery schedule available locally to support it in answering queries related to whether a person's medicine was out for delivery. The team retained prescriptions for owed medicines and dispensed using the prescription when later supplying

these medicines. Team members were observed contacting GP surgeries to inform them of medicines that were temporarily unavailable. And they provided details of suitable alternatives suggested by the RP for prescribers to consider during these calls.

The pharmacy had schedules to support it in managing work associated with the multi-compartment compliance pack services. It dispensed medicines in this way to some people living in the community and to people residing in local care homes and supported living accommodation. The pharmacy recorded the prescription requests made by care homes. This allowed the team to effectively manage queries in a timely manner. It supplied medicines to the homes in a range of ways, depending on the individual needs of the home. The pharmacy supplied medication administration records (MARs) with all medicines supplied for people living in care homes and supported living accommodation. The team used a variety of records, including individual patient profile sheets to help manage the supply of medicines in multi-compartment compliance packs. The profile sheets were updated with the changes made to medicine regimens. But supportive notes detailing the change were not always included. This limited the information the team had to support it in answering any queries about a medicine change. A sample of assembled compliance packs contained full dispensing audit trails and the team made efforts to ensure it supplied patient information leaflets at the beginning of every four-week cycle of compliance packs.

The pharmacy sourced medicines from licensed wholesalers. Medicine storage on shelves was orderly. But a small number of stock of medicines used to support compliance pack dispensing had been removed from their original blister packaging and were stored loosely in their original boxes. A discussion highlighted the risk of removing the medicines from their protective packaging. And a team member took appropriate action to remove these from use. The pharmacy had secure arrangements for storing medicines subject to safe custody arrangements. It had three fridges. Two of these were used by the team day-to-day. A third fridge was predominantly used by the COVID-19 vaccination service team. The team monitored the fridge temperature of its own fridges, but not of the third fridge. The RP thought this might be done remotely by the superintendent pharmacist. But it was not clear how this could be achieved with the equipment on site. The RP took the opportunity to add the fridge to the teams daily monitoring records. There was no indication that the fridge had been operating outside of the required temperature range of two and eight degrees Celsius. Monitoring records for the other two fridges found no concerns about the storage conditions of cold chain medicines.

Team members recorded regular date checking tasks on a matrix. A random check of medicines in the dispensary found no out-of-date medicines and short dated medicines were identified through the use of stickers. Liquid medicines contained details of the date they were opened. This supported team members in making checks to ensure liquid medicines with a shortened shelf-life once opened remained safe and fit to supply. The pharmacy had appropriate medicine waste receptacles, sharps bins and CD denaturing kits available and it stored these safely. The team received drug alerts via the NHS Central Alerting System, and it acted upon these alerts in a timely manner.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the appropriate equipment readily available to support it in delivering its services. Its team members use the equipment with care to protect people's confidential information.

Inspector's evidence

Pharmacy team members had access to a range of up-to-date electronic reference resources such as the British National Formulary (BNF) and BNF for children. They used the internet to help resolve queries and to obtain up-to-date information. Computers were password protected, and information on computer monitors was suitably safeguarded from unauthorised view. The pharmacy stored prescriptions and bags of assembled medicines behind the medicine counter in a retrieval system. This suitably protected personal details on bag labels and prescription forms. Members of the pharmacy team used cordless telephone handsets when speaking to people. The RP was observed moving into the consultation room when discussing confidential information.

The pharmacy had a range of clean equipment from recognised manufacturers to support the delivery of pharmacy services. This included counting apparatus for tablets and capsules, and crown stamped measuring cylinders for measuring liquid medicines. There was separate equipment available for counting higher-risk medicines to reduce any risk of cross contamination. The pharmacy had a service contract for its PMR system. This included its team members being able to call a helpdesk for remote support when required. Electrical equipment was clean and free from 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.