General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Winterhill Pharmacy, 2 Fellowsfield Way, Kimberworth, ROTHERHAM, South Yorkshire, S61 1NL

Pharmacy reference: 1099009

Type of pharmacy: Community

Date of inspection: 29/11/2023

Pharmacy context

This community pharmacy is on a housing estate in a suburb of Rotherham, South Yorkshire. Its main services include dispensing NHS prescriptions and selling over-the counter medicines. The pharmacy provides a seasonal flu vaccination service. It offers a medicine delivery service. And it 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

Follow this link to find out what the inspections possible outcomes mean

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 effectively identifies and manages the risks associated with providing its services. It uses the feedback it receives from people to inform the way it provides its services. The pharmacy mostly keeps the records it needs to by law. And it keeps people's confidential information secure. Pharmacy team members know how to respond to concerns to help protect vulnerable people. They behave openly and honestly by recording and discussing the mistakes they make when dispensing medicines. And they act to reduce risk following these mistakes.

Inspector's evidence

The pharmacy had standard operating procedures (SOPs) to support its safe and effective running. The current version of SOPs was published within the last year. Pharmacy team members accessed personal copies of them through an application and had read and understood those relevant to their role. The pharmacy's area manager monitored this training requirement. Pharmacy team members demonstrated a good understanding of their job roles through discussing and demonstrating the tasks they undertook. A team member discussed the tasks that they could not complete if the responsible pharmacist (RP) took absence from the premises.

The pharmacy had processes for managing mistakes that were identified during the dispensing process, known as near misses. Following a mistake being identified, team members checked their work again and corrected their work. They recorded the mistake on a digital near miss record. A sample of the near miss record showed recording was consistent. The RP led regular conversations about trends in mistakes. And the team acted to reduce risk following these conversations. For example, it had highlighted medicines with similar names on the dispensary shelves. And it had acted to separate higher-risk medicines to avoid the risk of a picking error. But the team did not record the outcomes of these conversations to help measure the effectiveness of the actions it took. The pharmacy had an incident reporting procedure in the event a mistake was identified following the supply of a medicine to a person, known as a dispensing incident. The RP reported these mistakes through the NHS 'Learning from Patient Safety Events' portal. They retained copies of incident reports which clearly highlighted the actions taken to reduce the risk of a similar mistake occurring.

The pharmacy advertised how people could provide feedback or raise a concern with the pharmacy. The team took feedback seriously and demonstrated how it used feedback to inform improvements to service delivery. For example, to reduce the risk of only handing out part of a prescription, team members now checked all prescriptions under the relevant letter in the alphabetised storage system when people attended to collect their medicines. Pharmacy team members had completed some learning to assist them in recognising and reporting safeguarding concerns about vulnerable people. The RP had completed safeguarding learning through the Centre for Pharmacy Postgraduate Education. Team members accessed procedures to support them in recognising and raising concerns, and current contact information for local safeguarding teams was available. They provided several examples of the steps they had taken to share concerns about vulnerable people with surgery teams to help support them. The pharmacy advertised support and wellbeing services available to people in the local area, and it advertised its consultation room as a safe space. Team members were familiar with code words promoted by national safety initiatives, designed to protect people who may be experiencing domestic

abuse.

The pharmacy protected people’s personal information by holding it within staff-only areas of the premises and on password protected computers. It held confidential waste safely and disposed of it securely through a specialist waste contractor. The pharmacy had current indemnity insurance arrangements. The RP notice displayed the correct details of the RP on duty. And the RP record was generally completed in full; occasional records made by locum pharmacists did not have the sign-out times of the RP. A sample of records made in the private prescription and controlled drug (CD) register met legal requirements. The pharmacy kept both registers electronically. The CD register was maintained with running balances. And pharmacists completed full physical balance checks of stock against the register regularly. A random physical balance check of a CD completed during the inspection matched the balance recorded in the CD register. The pharmacy held a record of the patient-returned CDs it received. It generally recorded returns at the time of receipt; one return which had been received the day before the inspection was waiting to be entered into the register.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has an appropriately qualified and skilled team to provide its services. And it suitably adapts its services and ways of working during periods of pressure. Its team members work together well to provide services safely and effectively. They benefit from regular appraisals to support their learning and development. And the pharmacy uses their feedback and ideas to inform the way it provides its services. Team members engage in some ongoing discussions to share learning. And they know how to raise a concern at work.

Inspector's evidence

On duty was the RP who was the pharmacy manager, a pharmacy technician, a qualified dispenser, two apprentices, a delivery driver, a trainee dispenser, and a new team member who was completing their induction. The pharmacy had recently experienced a turnover of staff with three team members leaving, including an accuracy checking pharmacy technician. The trainee dispenser was a member of the company's wider relief team and was currently working at the pharmacy regularly. The pharmacy was recruiting to address a further dispenser vacancy. The team had reviewed its workflow due to reduced support for completing accuracy checks of medicines. The RP discussed the recent period of increased pressure due to the staffing changes. They were supported by the pharmacy's area manager and superintendent pharmacist and explained that additional pharmacist cover had been arranged on occasion to support the team. The company owned several pharmacies in the Rotherham area and team members worked across different pharmacies if needed to provide support. The pharmacy had some targets associated with the services it provided. The RP provided examples of using their professional judgment when undertaking services. And they felt the SI was supportive of the need to scale back some services due to the recent changes in skill mix and staffing. There was some support to ensure NHS advanced services remained available to people. For example, another company employed pharmacist would complete NHS New Medicine Service consultations to reduce pressure on the RP.

Pharmacy team members were observed working well together. Trainee team members felt supported in their learning roles. And they were confident in asking questions and requesting assistance when undertaking tasks. All team members engaged in regular learning at work. This included conversations to support them in dispensing medicines safely. The SI encouraged regular learning by sharing topics of interest within a secure messaging application. Team members were supported through a formal appraisal process. And they felt able to feedback in these reviews. The pharmacy had a whistle blowing policy. Team members felt confident in sharing feedback, and they understood how to raise and escalate a concern at work. They provided examples of their feedback being used by the pharmacy to inform the way it provided its services. For example, the RP had suggested turning a stock room into a dedicated dispensary for dispensing multi-compartment compliance packs. In response to this feedback, the room had been professionally fitted out to support the team in using the space safely.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is secure, clean, 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 secure and maintained to an appropriate standard. Team members knew how to report maintenance concerns and confirmed there were no current maintenance issues. The pharmacy was clean and tidy. Floor spaces were free from trip and fall hazards. Lighting was bright and heating and ventilation arrangements were sufficient. Pharmacy team members had access to sinks equipped with appropriate hand washing materials.

The public area was fitted with wide spaced aisles. A small consultation room was available to support private conversations with people. This room was accessible off the public area, and it was observed being used with people during the inspection. The staff-only area of the pharmacy was separated by the medicine counter. A lift-up hatch on the counter deterred unauthorised access into this area. Space in the dispensary was managed well. The separate multi-compartment compliance pack dispensary assisted the team in reducing distractions when completing tasks for this service. The RP had a dedicated checking area in both dispensaries. To the back of the pharmacy was a staff room and staff toilet facilities. Shelving running along a wall of the staff room provided storage space for items such as capped medicine bottles and bags.

Principle 4 - Services ✔ Standards met

Summary findings

Overall, the pharmacy's services are accessible for people. It has appropriate arrangements to help people in the event it is unable to provide a service. The pharmacy obtains its medicines from reputable sources. It generally stores these medicines safely and securely. Pharmacy team members make regular checks to ensure medicines are safe to supply to people. And they provide information to people when supplying medicines, to help them take them safely.

Inspector's evidence

People accessed the pharmacy from a raised walkway from street level. This required people needing to walk up two steps before they could access some businesses within the parade of shops. The pharmacy offered a medicine delivery service to people who were not able to physically access the premises. And team members explained they would support access by going outside to help people. Or by providing supportive information so people could access a service at another local pharmacy.

The pharmacy protected Pharmacy (P) medicines from self-selection by displaying them behind the medicine counter. The team were vigilant of repeat requests for some P medicines that were subject to misuse. And the RP reflected on occasions where they had refused a sale and signposted people to see their GP. The pharmacy team was aware of the requirements of the valproate Pregnancy Prevention Programme (PPP). And the RP discussed their approach to counselling when supplying valproate. The team was aware of recent legal changes to the supply of valproate in original packs. The team highlighted some higher-risk medicines during the dispensing process. And the RP provided examples of verbal counselling they undertook when supplying these medicines. But they did not generally record these conversations on the patient medication record to support continual care.

The RP had access to current information to support them in delivering consultation services effectively. This included signed copies of patient group directions for the flu vaccination service. The team managed dispensing tasks well. It kept each person's prescription separate throughout the dispensing process by using coloured baskets. The baskets also helped to identify workload priority. The pharmacy offered a text messaging service to people to alert them when their medicines were ready to collect. Team members took ownership of the tasks they completed. For example, they signed the 'dispensed by' and 'checked by' boxes on medicine labels to form a dispensing audit trail. And they initialled prescriptions to confirm they had transferred an assembled bag of medicines to the retrieval area. A team member explained this helped to manage queries should a team member be unable to find a bag. The pharmacy had an effective process to manage the medicines it owed to people. This included separating prescriptions for medicines currently unavailable due to long-term stock shortages. This allowed team members to make regular checks of availability and speak to people and prescribers about the need to consider an alternative. The pharmacy kept an audit trail of the deliveries it made to people. Team members provided several positive examples of the steps they took to help ensure people received their medicines on time. This included sharing learning with each other following feedback from people.

The pharmacy used effective records to manage workload when supplying medicines in multi-compartment compliance packs. Due to local NHS policies, people ordered their own prescriptions. The

pharmacy made regular checks to ensure it received these in good time, to reduce the risk of a vulnerable person experiencing a delay in receiving their medicine. The pharmacy used individual records for each person on the service to record medicine regimens. Changes to medicine regimens were checked with surgery teams and clearly recorded within people's individual records. The RP regularly signed compliance packs as part of their accuracy check. But team members did not generally record their role in assembling a compliance pack. The RP explained they would know who had assembled a compliance pack as one team member was assigned to this task for a specific period. Backing sheets attached to compliance packs included clear descriptions of the medicines inside and details of when to take each medicine. And the pharmacy routinely provided patient information leaflets when suppling medicines in this way.

The pharmacy sourced medicines from licensed wholesalers and a specials manufacturer. Pharmacies within the ownership group used a secure messaging application to source stock from each other when it was not obtainable through the wholesalers. It generally stored medicines in their original packaging in an orderly manner throughout the dispensary. Some medicines stored in white boxes were found in stock. Full details of the medicine inside, such as the batch number and expiry date were not recorded on the outside of the box. This meant it was more difficult for team members to make checks to ensure the medicines remained safe to supply. This was brought to the RP's attention. The pharmacy stored CDs in secure cabinets. Medicines inside were held in an orderly manner with expired stock and patient returned CDs clearly separated. The pharmacy kept medicines requiring cold storage in two fridges. One fridge was relatively new, a team member explained they checked the temperature of both fridges each day and both had remained within the required temperature range. But they only recorded the temperature range of one fridge as a second record had not been set up. The opportunity was taken to set up a second record during the inspection to support with recording temperatures for both fridges moving forward. The pharmacy team completed regular expiry date checks of stock medicines and it kept records of the checks it made. A random check of dispensary stock found no out-of-date medicines. The pharmacy had medicine waste receptacles, sharps bins and CD denaturing kits available. The RP demonstrated how the team received medicine alerts through a digital portal. The team recorded 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 its equipment to ensure it remains in safe working order. And pharmacy team members use the equipment in a way which protects people’s confidentiality.

Inspector's evidence

Pharmacy team members had access to physical and digital reference resources. They also used the internet to help them look up information. They used password protected computers and NHS smartcards to access people’s medication records. The pharmacy suitably protected information on computer monitors from unauthorised view. It stored bags of assembled medicines in a retrieval system within the dispensary. This arrangement suitably protected people’s personal information on bag labels and prescriptions. Team members used a cordless telephone handset, this allowed them to take calls out of earshot of the public area.

Pharmacy team members used CE marked counting and measuring equipment when dispensing medicines. This included separate equipment for counting and measuring higher-risk medicines which mitigated any risk of cross contamination when dispensing these medicines. Appropriate equipment to support the emergency treatment of anaphylactic reaction was available. Equipment used to support the delivery of pharmacy services was from recognised manufacturers. The RP explained the ambulatory blood pressure monitor was recently out of use following a concern it may not be working as intended. Arrangements were being made to check the machine before it was used again. Electrical equipment was subject to periodic safety testing.

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.