General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: North Walsham Pharmacy, Birchwood Medical Practice, Park Lane, NORTH WALSHAM, Norfolk, NR28 0BQ

Pharmacy reference: 1105567

Type of pharmacy: Community

Date of inspection: 21/06/2023

Pharmacy context

The pharmacy is next to a surgery in a largely residential area. It provides NHS dispensing services, the New Medicine Service and blood pressure checks. And it supplies medicines as part of the Community Pharmacist Consultation Service. The pharmacy supplies medications in multi-compartment compliance packs to a small number of people who live in their own homes and need this support. And it provides substance misuse medications to a small number of people. The pharmacy receives most of its prescriptions electronically.

Overall inspection outcome

Standards not all met

Required Action: Improvement Action Plan

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 not all met	2.2	Standard not met	The pharmacy does not always ensure that team members are enrolled on an accredited course for their role within the required timeframe.
3. Premises	Standards not all met	3.1	Standard not met	The pharmacy does not keep its premises free from tripping hazards. And it does not always store dispensed items safely.
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

Overall, the pharmacy adequately identifies and manages the risks associated with its services to help provide them safely. It learns from mistakes that happen during the dispensing process to help make its services safer. And people can provide feedback about the pharmacy's services. It keeps its records largely accurate and up to date. And team members understand their role in protecting vulnerable people. The pharmacy generally protects people's personal information well.

Inspector's evidence

The pharmacy had standard operating procedures (SOPs) and the pharmacist explained that they were in the process of being reviewed and updated. Team members had signed to show that they had read, understood, and agreed to follow them. The pharmacy managed its near misses (where a dispensing mistake was identified before the medicine had reached a person) well. The near misses were highlighted with the team member involved at the time of the incident. And once the mistake was highlighted, team members were responsible for identifying and rectifying their own mistakes. Near misses were recorded and reviewed regularly for any patterns. Items in similar packaging or with similar names were separated where possible to help minimise the chance of the wrong medicine being selected. The pharmacist said that the outcomes from the reviews were discussed openly during the regular team meetings. And learning points were also shared with other pharmacies in the group. The pharmacist said that she was not aware of any recent dispensing errors, where a dispensing mistake had happened and the medicine had been handed to a person. She said that dispensing errors would be recorded on a designated form and a root cause analysis undertaken. And the pharmacy's head office would be informed. The complaints procedure was available for team members to follow if needed and details about it were available in the pharmacy leaflet. The director explained how the company dealt with complaints and said that they were also discussed with the team.

There was limited clear space for team members to dispense. The pharmacist had a clear area for checking dispensed items. The team members signed the dispensing label when they dispensed and checked each item to show who had completed these tasks. And baskets were used to minimise the risk of medicines being transferred to a different prescription. But there were baskets piled high covering most of the surfaces in the dispensary. And there was a risk that these would topple over.

Team members said that the pharmacy would remain closed if the pharmacist had not turned up in the morning. They said that they would attempt to contact the pharmacist and would inform the pharmacy's head office. Team members knew which tasks they should not undertake if there was no responsible pharmacist (RP) signed in. The trainee medicines counter assistant (MCA) knew that she should not sell any pharmacy-only medicines or hand out dispensed items if the pharmacist was not in the pharmacy. Team members' roles and responsibilities were specified in the SOPs.

The pharmacy had current professional indemnity and public liability insurance. Controlled drug (CD) registers examined were filled in correctly, and the CD running balances were checked at regular intervals. Liquid overage was recorded in the register. The recorded quantity of one CD item checked at random was the same as the physical amount of stock available. The private CD prescriptions had not been sent to the relevant authority since at least February 2023. The pharmacist said that she would address this. The nature of the emergency was routinely recorded when a supply of a prescription-only

medicine was supplied in an emergency without a prescription. Private prescription records were largely completed correctly, but the prescriber's details were not always recorded. This could make it harder for the pharmacy to find these details if there was a future query. The pharmacist said that she would ensure that these were recorded in future. The right RP notice was clearly displayed, and the RP record was largely completed correctly. But there were several occasions where the RP had not signed out and there was a different pharmacist working the following day. This was discussed with the pharmacist, and she said that she would discuss this with the team.

People's personal information on bagged items awaiting collection could not be viewed by people using the pharmacy. And people using the pharmacy could not see information on the pharmacy's computer screens. The pharmacy ensured that its confidential waste was shredded, and its computers were password protected. A team member's smartcard was the only card in use during the inspection but they were not working on that day. And another team member who had been working at the pharmacy for around two years said that she had never had her own smartcard. The director said that the pharmacy had applied for smartcards for some team members, but he was not sure who. He said that the pharmacy had struggled to get them. The pharmacist had her own smartcard and was prompted by the director to use it.

Team members had completed the Centre for Pharmacy Postgraduate Education training about protecting vulnerable people. One of the team described potential signs that might indicate a safeguarding concern and said that she would refer any concerns to the pharmacist. She was not aware of any safeguarding concerns encountered by the pharmacy. The pharmacy had contact details available for agencies who dealt with safeguarding vulnerable people.

Principle 2 - Staffing **Standards not all met**

Summary findings

The pharmacy does not always ensure that team members are enrolled on approved pharmacy courses within the required time frame. This could mean that they do not have all the skills and knowledge they need to undertake their tasks safely. Team members are provided with some ongoing training to support their learning needs and maintain their knowledge and skills. And they can raise any concerns or make suggestions and have regular meetings. Team members can take professional decisions to ensure people taking medicines are safe. The pharmacy has enough team members to manage its workload. But its current skill mix means some tasks may be delayed at times, putting pressure on storage space.

Inspector's evidence

There was one regular pharmacist, one trainee pharmacist, one trained dispenser, one trainee dispenser, and one trainee MCA working during the inspection. Most team members had completed an accredited course for their role, and some were undertaking training. The trainee MCA said that she had worked at the pharmacy for around five months but had not been enrolled on an accredited course. One of the directors of the company arrived at the pharmacy shortly after the start of the inspection. The director confirmed that there were no other team members who needed to be enrolled on a course. He said that the team member would be enrolled on an appropriate course promptly and would send confirmation of this to the inspector, but this was not received.

The team said that the pharmacy was up to date with assembling its prescriptions. But the vast number of prescriptions waiting to be checked indicated that the pharmacy was not managing to keep up with accuracy checking these. The director said that he would consider enrolling one of the dispensers on an accuracy checking course to help the pharmacist with her workload. The pharmacist said that the pharmacy received most of its prescriptions on Monday and Tuesday and by the end of the week it received fewer prescriptions. And this meant that the workload was easier to manage and there was more space available for team members to dispense.

The trainee MCA appeared confident when speaking with people. She said that she would refer to the pharmacist if a person asked to buy more than one box of pseudoephedrine-containing medicines. Or if a person regularly requested to purchase medicines which could be abused or may require additional care. She asked relevant questions to establish whether a medicine was suitable for the person it was intended for.

One of the team said that team members did not receive regular ongoing training, but they did receive some on an ad hoc basis. She said that the pharmacist passed on information informally and she had recently completed some training for the Pharmacy Quality Scheme. The pharmacist was aware of the continuing professional development requirement for professional revalidation. She said that had recently completed some training about inhaler techniques and about safeguarding vulnerable people. And she felt able to make professional decisions.

Team members shared information with each other in a messaging app to ensure that it reached the whole team promptly. And other information was passed on informally during the day. Team members said that the regional manager visited the pharmacy around twice a month to discuss any ongoing

issues. Team members felt comfortable about discussing any issues with the pharmacist or the regional manager. One team member said that she had had an appraisal shortly after starting to work at the pharmacy but had not had one since. Team members had ongoing informal performance reviews. Targets were not set for team members. The pharmacist said that the services were provided for the benefit of the people using the pharmacy.

Principle 3 - Premises **Standards not all met**

Summary findings

The pharmacy does not, at times, have adequate space for dispensing prescriptions and for storing dispensed items in an organised and safe way. And floor areas are not kept clear of tripping hazards. The premises are secure from unauthorised access. And people can have a conversation with a team member in a private area.

Inspector's evidence

Floor space in the dispensary was limited due to the presence of delivery boxes and baskets with assembled prescriptions, and these presented tripping hazards. The work surfaces were almost entirely covered with stacks of baskets with assembled prescriptions and team members had very little clear workspace. A stack of baskets fell to the floor during the inspection and some of the medicines spilled out onto the floor.

The pharmacy was secured from unauthorised access and the shop area presented a professional image. Pharmacy-only medicines were kept behind the counter. Air conditioning was available, and the room temperature was suitable for storing medicines. There was one chair in the shop area, and it was positioned away from the medicines counter to help minimise the risk of conversations at the counter being heard.

The consultation room was suitably equipped and well-screened. Conversations at a normal level of volume in the consultation room could not be heard from the shop area. The room was currently accessible from behind the medicines counter. The door to the shop area had a large number of boxes stored behind it so it was not being used. A team member said that people would not be left on their own while accessing and using the consultation room.

Toilet facilities were available in the surgery. They were clean and not used for storing pharmacy items. There were separate hand washing facilities available.

Principle 4 - Services ✔ Standards met

Summary findings

Overall, the pharmacy provides its services safely and manages them well. The pharmacy gets its medicines from reputable suppliers. It responds appropriately to drug alerts and product recalls. And it makes sure that its medicines and devices are safe for people to use. People with a range of needs can access the pharmacy's services. But the pharmacy doesn't always highlight prescriptions for higher-risk medicines. And this may mean that it misses opportunities to speak with people when they collect these medicines.

Inspector's evidence

There was step-free access to the pharmacy through a wide entrance. Team members had a clear view of the main entrance from the medicines counter and could help people into the premises where needed. Services and opening times were clearly advertised and a variety of health information leaflets was available. Team members said that the pharmacy produced large-print labels for people who needed them.

Prescriptions for higher-risk medicines were not highlighted. So, opportunities to speak with these people when they collected their medicines might be missed. The pharmacist said that the surgery would not usually issue a prescription if the person needed to have a blood test. Prescriptions for Schedule 3 and 4 CDs were not highlighted. And this could increase the chance of these medicines being supplied when the prescription was no longer valid. Team members said that they would consider highlighting these in future. Dispensed fridge items were kept in clear plastic bags to aid identification. The pharmacist said that team members checked CDs and fridge items with people when handing them out. A team member said that the pharmacy supplied valproate medicines to a few people. But there were currently no people in the at-risk group who were on the Pregnancy Prevention Programme (PPP). A different team member said that people would be referred to their GP if they were not on a PPP and needed to be on one.

The pharmacy used licensed wholesalers to obtain medicines and medical devices. Drug alerts and recalls were received from the NHS and the MHRA. But the pharmacy did not keep a record of any action it had taken, which could make it harder for the pharmacy to show what it had done in response. The pharmacist said that she would ensure that a record of what it had done would be kept in future. Stock was stored in an organised manner in the dispensary. Expiry dates were checked regularly, and this activity was recorded. Items due to expire within the next six months were marked. There were no date-expired items found in with dispensing stock and medicines were kept in appropriately labelled containers. The fridges were suitable for storing medicines and were not overstocked. Fridge temperatures were checked daily, and maximum and minimum temperatures were recorded. Records indicated that the temperatures were consistently within the recommended range. CDs were stored in accordance with legal requirements, and they were kept secure. Denaturing kits were available for the safe destruction of CDs. CDs that people had returned, and expired CDs were clearly marked and segregated. Returned CDs were recorded in a register and destroyed with a witness, and two signatures were recorded.

Uncollected prescriptions were checked monthly and kept in the pharmacy for around two months. Team members said that the pharmacy contacted people to ask if they needed the medicines before

they were returned to dispensing stock where possible. Uncollected prescriptions were returned to the NHS electronic system or to the prescriber. Part-dispensed prescriptions were checked frequently. 'Owings' notes were provided when prescriptions could not be dispensed in full, and people were kept informed about supply issues. Prescriptions for alternative medicines were requested from prescribers where needed. Prescriptions were kept at the pharmacy until the remainder was dispensed and collected.

People had assessments to show that they needed their medicines in multi-compartment compliance packs. The pharmacy kept a record for each person which included any changes to their medication. Prescriptions for people receiving their medicines in the packs were ordered in advance so that any issues could be addressed before people needed their medicines. Prescriptions for 'when required' medicines were not routinely requested. A team member said that people usually contacted the pharmacy to request these when their packs were due. Packs were suitably labelled and there was an audit trail to show who had dispensed and checked each pack. Medication descriptions were put on the packs to help people and their carers identify the medicines. But patient information leaflets were not routinely supplied. This could make it harder for people to have up-to-date information about how to take their medicines safely. The pharmacist said that she would ensure that these were supplied in future.

Deliveries were made by a delivery driver. The delivery driver said that he signed for CDs to show that he had taken them for delivery. But he did not ask people to sign for them. This could make it harder for the pharmacy to show that the medicines were delivered to the right person. When the person was not at home, the delivery was returned to the pharmacy before the end of the working day. A card was left at the address asking the person to contact the pharmacy to rearrange delivery.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide its services safely. It uses its equipment to help protect people’s personal information.

Inspector's evidence

Suitable equipment for measuring liquids was available and separate measures were used to measure certain medicines only. Triangle tablet counters were available and clean. Methotrexate came in foil packs and there was no need for the loose tablets to be counted out in a triangle. Tweezers were available so that team members did not have to touch the medicines when handling loose tablets or capsules. Up-to-date reference sources were available in the pharmacy and online. The shredder was in good working order and the phone in the dispensary was portable so it could be taken to a more private area where needed.

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.