General
Pharmaceutical
Council

Registered pharmacy inspection report

Pharmacy Name: Wickersley Pharmacy, Morthen Group Practice, 2 Morthen Road, Wickersley, ROTHERHAM, South Yorkshire, S66 1EU

Pharmacy reference: 1107968

Type of pharmacy: Community

Date of inspection: 16/10/2024

Pharmacy context

The pharmacy is within a GP surgery in the village of Wickersley, close to Rotherham in South Yorkshire. Its main services include dispensing NHS prescriptions and providing NHS consultation services to people. These include the New Medicine Service (NMS), blood pressure checks, Pharmacy First and COVID-19 vaccinations. The pharmacy sells pharmacy (P) medicines, and it supplies some medicines in multi-compartment compliance packs, designed to help people remember to take their medicines. It also offers a medicine delivery service.

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 met	N/A	N/A	N/A
3. Premises	Standards not all met	3.1	Standard not met	The pharmacy is disorganised. Clutter within the dispensary is impacting on the safe completion of dispensing tasks and is risking team members health and safety.
		3.4	Standard not met	The pharmacy does not have adequate security arrangements.
4. Services, including medicines management	Standards not all met	4.3	Standard not met	The pharmacy does not store and manage all its medicines as it should and in accordance with legal requirements. It does not make effective checks to ensure all medicines are safe to supply. And it does not store its medicine waste appropriately.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance ✔ Standards met

Summary findings

Overall, the pharmacy identifies and manages the risks for the services it provides. It keeps people's confidential information secure. And it generally keeps the records it must by law. Pharmacy team members know how to respond to feedback they receive about the pharmacy. They understand how to recognise, and report concerns to help keep vulnerable people safe from harm. And they take some opportunities to share learning following mistakes they make during the dispensing process.

Inspector's evidence

The pharmacy had its current version of standard operating procedures (SOPs), designed to support its safe and effective running available for team members to refer to. Most team members had signed these SOPs to confirm they had read and understood them. Newer members of the team were in the process of reading the SOPs. Pharmacy team members were observed following SOPs when working. For example, completing address checks with people when handing out assembled bags of medicines. A team member explained what tasks they could not complete should the responsible pharmacist (RP) take absence from the pharmacy.

The pharmacy had processes to support its team members in learning from the mistakes they made and identified during the dispensing process, known as near misses. And from any mistakes identified following the supply of a medicine to a person, known as dispensing incidents. The RP discussed how they would manage a dispensing incident and provided evidence of the steps they had taken to report a recent incident to the pharmacy's supervisor. A team member explained they would look again at their work and correct mistakes following feedback from the RP. And the pharmacy's supervisor led conversations to help the team reflect on mistakes and act to reduce risk. But near miss reporting rates had reduced within the last few months. This meant the team had potentially missed the opportunity to share learning during these conversations. Team members explained they had experienced a large rise in workplace pressure following several long-serving team members leaving the pharmacy within a short period. This had led to increased feedback from people using the pharmacy and some tasks, such as near miss reporting not being completed. Team members reported that the pharmacy's area manager and new pharmacist manager had worked together effectively to support the team during this difficult period. And they demonstrated how day-to-day dispensing workload was now up to date. A discussion highlighted the importance of using records such as near miss reporting to help identify and manage risks linked to workload pressures.

The pharmacy had a complaints procedure, and its team members had a clear understanding of how to listen to and respond to feedback they received about the pharmacy. They understood how to escalate concerns and explained they had referred some concerns to the pharmacy's area manager who had personally contacted people to discuss their feedback. The team felt complaints had reduced since being back on track with its workload. The pharmacy stored personal-identifiable information within the dispensary and on password protected computers. It had appropriate arrangements to dispose of confidential waste securely. Team members completed learning about the importance of safeguarding vulnerable people. A team member discussed how they would identify and report a concern about a potentially vulnerable person to the pharmacy's manager or RP. And the RP explained how they would find information for local safeguarding teams to support them in raising a safeguarding concern.

The pharmacy had current professional indemnity insurance. The RP notice on display was updated as the inspection began to reflect the correct details of the RP on duty. Pharmacists signed into the RP record as required but they did not always sign out of the record to show the time they had ceased their role. The pharmacy kept its controlled drug (CD) register electronically. It maintained running balances within the register and regular full balance checks of physical stock against the balances in the register took place. Random physical balance checks completed during the inspection matched the balances in the CD register. A sample of entries within the CD register were seen to comply with legal recording requirements. The pharmacy kept a record of the private prescriptions it dispensed. But entries in its private prescription register did not always contain accurate details of the prescriber. It completed accurate records when dispensing unlicensed medicines.

Principle 2 - Staffing ✔ Standards met

Summary findings

Pharmacy team members have the knowledge and skills required to provide the pharmacy's services effectively. They work together well, and they engage in conversations to support them in managing patient safety. Team members complete some ongoing learning to support them in working safely. And those in training roles are appropriately supervised when conducting tasks.

Inspector's evidence

The RP on duty was a locum pharmacist. They were supported by four qualified dispensers, three apprentices and a foundation trainee pharmacist. The pharmacy also employed a supervisor who was a pharmacy technician. It had recently appointed a regular pharmacist manager who worked four days each week. A company-employed delivery driver provided the medicine delivery service. The pharmacy had acted to employ locum team members when it had become clear that team members were not able to cope with workload following the departure of several staff in quick succession. Team members provided examples to demonstrate how day-to-day dispensing activity was up to date.

Trainee members of the team were supervised appropriately whilst completing tasks. And they felt comfortable asking questions and clarifying information when working. But due the recent high turnover of team members those in training roles had not received the protected time their employment arrangements required them to have to support them with their learning. The pharmacy’s area manager provided assurances that this matter was being addressed with the pharmacy manager to ensure this learning time was available. Team members demonstrated some learning they had completed to support the safe delivery of the pharmacy’s services. For example, the blood pressure check service. The pharmacy had a whistleblowing policy and team members, including those in training roles knew how to raise and escalate a concern at work. Team members were observed working well together and communicated effectively with each other to resolve queries. They engaged in regular discussions about workload and patient safety.

Principle 3 - Premises Standards not all met

Summary findings

Clutter within the pharmacy compromises workflow and is causing health and safety hazards for team members. And the pharmacy doesn't do enough to suitably maintain all aspects of its security. The premises are adequately clean and people accessing the pharmacy can speak to a team member in a private consultation room.

Inspector's evidence

The pharmacy was small consisting of the dispensary and a consultation room. The surgery building was kept secure outside of working hours. But a maintenance issue with security in the pharmacy was outstanding. Both the dispensary and consultation room were disorganised. For example, some prescription-only medicines were on the floor in the consultation room as the inspection began, and some areas of the dispensary floor were used to hold baskets of stock. Further boxes containing bags of assembled items compromised floor space and made it difficult for team members to navigate their way around the pharmacy. An incident occurred during the inspection which required the need for a team member to repeat some dispensing tasks due to medicines falling on the dispensary floor due to lack of space for team members to navigate around each other. Workbenches were cluttered with the exception of the pharmacist’s checking station which was a good size and offered a protected space for completing the final accuracy checks of medicines. A team member assembling medicines in multi-compartment compliance packs only had enough space on the dispensary work bench to lay-out three of the four compliance packs required for a four-week supply of medicines. This meant they had to repeat assembly tasks when assembling the fourth compliance pack which heightened the risk of a mistake occurring.

The pharmacy was generally clean. Air conditioning controlled the temperature year-round, and lighting was adequate. Team members had access to hand washing facilities and break facilities within the surgery building. The consultation room was accessible to people. But the room was cluttered and did not present a professional image to people visiting the pharmacy for a consultation.

Principle 4 - Services **Standards not all met**

Summary findings

The pharmacy does not store all of its medicines safely and securely. And it does not make effective checks to ensure all medicines are stored in a suitable environment and remain safe to supply to people. The pharmacy obtains its medicines from reputable sources. And its services are accessible to people.

Inspector's evidence

People accessed the pharmacy through automatic doors leading from the surgery carpark. The pharmacy advertised its opening hours and some information about the services it provided. It sold a small selection of Pharmacy (P) medicines, it protected these from self-selection by holding them in locked display cabinets. Team members were observed communicating effectively with the surgery team to resolve queries during the inspection. And they knew how to signpost people to an alternative healthcare provider or pharmacy if required.

The pharmacy had some supporting information available for pharmacists providing NHS consultation services such as the service specification and patient group directions (PGDs) for providing the Pharmacy First service. Most of this information was available digitally. Information to support the COVID-19 vaccination service was not seen. The team explained the SI provided this service on a Sunday only and had this information available to them.

The pharmacy had some processes for identifying higher-risk medicines and providing counselling to people taking these medicines. For example, the RP was required to double check an assembled CD prior to it being handed out. The SI discussed the counselling they provided when supplying higher-risk medicines, including those requiring people to have pregnancy prevention plans in place. But they were not aware of a recently issued update to the valproate Pregnancy Prevention Programme (PPP) which may have required them to provide counselling to men taking the medicine. The RP took the opportunity to find this information on the internet to support their understanding of the new requirements. The pharmacy had identified a need to dispense valproate outside of its original packaging. But it had not completed a risk assessment as required to support it in dispensing the medicine in this way. A discussion highlighted the need to comply with all requirements of medicine related PPPs.

Pharmacy team members used coloured baskets throughout the dispensing process to help keep all items for each prescription together. This also helped the team to identify priority workload. Team members generally completed dispensing audit trails by applying their dispensing signatures within the 'dispensed-by' and checked-by' boxes on medicine labels. But they did not always apply their dispensing signature when assembling medicines in multi-compartment compliance packs. The pharmacy used a task tracker to support the management of work for the multi-compartment compliance pack service. The team effectively recorded the checks they made when changes were applied to people's medication regimens. A sample of assembled compliance packs were labelled with clear information and descriptions of the medicines inside. But the pharmacy did not routinely provide patient information leaflets when supplying medicines in this way to ensure people had all the information available to support them in taking their medicines safely. The pharmacy retained

prescriptions for the medicines it owed to people. And it used these prescriptions when dispensing owed medicines. It recorded the deliveries it made to people's homes to support it in resolving any queries about the delivery service.

The pharmacy sourced medicines from licensed wholesalers and a licensed specials manufacturer. Storage of medicines was disorganised with some medicines stored in stacked baskets on the dispensary floor, and bottles of an antibiotic powder for reconstitution were laid on the floor of the consultation room as the inspection began. The pharmacy did not store its CDs in accordance with requirements. The pharmacy held medicines requiring cold storage in three fridges. But it only monitored and recorded the operating temperature range of the two fridges within the dispensary. This meant that there were no assurances of the operating temperature range of the fridge within the consultation room which held medicines. The team were behind with some stock management tasks, including its routine checks of the expiry date of medicines. And they did not always record the opening date on bottles of liquid medicines to ensure any contents left in the bottle remained safe to dispense. A random check of stock held in the dispensary found no out-of-date medicines. And team members were observed checking the expiry date of medicines during the dispensing process. The pharmacy had medicine waste bins available for storing out-of-date and patient-returned medicines. But the bin in current use was overflowing and was not held in a secure location. A team member demonstrated how the pharmacy received and actioned drug safety alerts and medicine recalls.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it requires to support the delivery of its services. And its team members use the equipment in a way which protects people's privacy.

Inspector's evidence

Pharmacy team members accessed digital reference resources and the internet to help them resolve queries and obtain up-to-date information. They used password-protected computers and NHS smartcards when accessing people's medication records. The pharmacy suitably protected information on computer monitors from unauthorised view. It generally stored medicines on designated shelving within the dispensary. But it was also storing these in plastic boxes on the dispensary floor and close to the public-facing counter. Confidential information on bag labels could not be read from the public-facing counter. The pharmacy had recently experienced an issue with its system not sending automated text messages to people to inform them their medicine was ready for collection. A team member explained the backlog of collections was being addressed through team members contacting people and informing them they had medicines ready to collect.

Pharmacy team members mostly used standardised counting and measuring equipment when dispensing medicines. But two plastic measuring cylinders did not bear any mark to show they were calibrated to measure accurately. A discussion highlighted the need to replace these with standardised stamped measuring cylinders. The pharmacy had equipment available to support its NHS consultation services, this was from recognised manufacturers and was clean and available for use. But the pharmacy only had one pre-filled adrenaline pen available readily available for emergency treatment of anaphylactic shock. Further supplies of adrenaline which were available within the dispensary. During a conversation after the inspection, the SI acknowledged the need to ensure protected stock of adrenaline was immediately available to support the service prior to the next vaccination clinic running.

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.