General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Whistlers Pharmacy, Beaumond Chambers, London Road, NEWARK, Nottinghamshire, NG24 1TN

Pharmacy reference: 1109445

Type of pharmacy: Community

Date of inspection: 25/09/2019

Pharmacy context

This is a community pharmacy in the centre of a busy market town in Nottinghamshire. The pharmacy sells over-the-counter medicines and dispenses NHS and private prescriptions. It offers advice on the management of minor illnesses and long-term conditions. It supplies medicines in multi-compartmental compliance packs, designed to help people remember to take their medicines. It delivers medicines to people's homes and to two local care 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	1.4	Good practice	The pharmacy encourages feedback from people using its services. It displays the results of this feedback. And it uses this feedback to work together with other healthcare professionals. The results of this teamwork helps ensure a streamlined approach to people accessing their medicines.
2. Staff	Standards met	2.5	Good practice	The pharmacy actively encourages feedback from its team members through regular performance and development reviews. It uses the feedback it receives to inform the safe management of its services.
3. Premises	Standards met	N/A	N/A	N/A
4. Services, including medicines management	Standards met	4.1	Good practice	The pharmacy has actively considered the possible barriers to people accessing some urgently required services out-of-hours. And it has taken steps to overcome these barriers and respond to the specific needs of the local community.
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. It protects people's personal information. And it keeps the records it must by law. The pharmacy encourages feedback from people using its services. It displays the results of this feedback. And it uses this feedback to work together with other healthcare professionals. The results of this teamwork helps ensure a streamlined approach to people accessing their medicines. The pharmacy team members are clear about their roles and responsibilities. They discuss their mistakes and make changes to help to reduce risk. But they do not always record the mistakes they identify during the dispensing process. This may mean there are some missed learning opportunities.

Inspector's evidence

The pharmacy had a set of up-to-date standard operating procedures (SOPs). A pharmacist director had reviewed the SOPs very recently. But not all SOPs contained details of this latest review date. The next documented review date was 2020. The SOPs included responsible pharmacist (RP) requirements, controlled drug (CD) management, dispensary procedures and services. Roles and responsibilities of pharmacy team members were included. Some members of the team were still reading and signing the updated SOPs relevant to their roles. Pharmacy team members were observed working in accordance with dispensing SOPs throughout the inspection. A team member discussed what tasks could and could not be completed if the RP took absence from the pharmacy.

The pharmacy managed its workload between two dispensaries. This provided plenty of space for dispensing activity. And it helped manage risks associated with high-risk services. For example, pharmacy team members assembled medicines in multi-compartmental compliance packs in the back dispensary. This effectively reduced the risk of interruption during the dispensing process.

A pharmacy team member explained how she would receive feedback from the pharmacist following identification of a near-miss error. And pharmacy team members worked to correct their own mistakes. There was an electronic reporting tool available for reporting these types of mistakes. But reporting rates were very low compared to the volume of items dispensed. This meant there were limited opportunities to review trends in mistakes with the whole pharmacy team and share this learning. A discussion took place about the benefits of recording these mistakes, as set out in the GPhC guidance to ensure a safe and effective pharmacy team. Pharmacy team members could demonstrate some actions they had taken to reduce risk following near-miss errors. For example, the team members frequently made each other aware of similarities in the packaging of different medicines when unpacking the pharmacy order. And they separated some 'look-alike and sound-alike' medicines on the dispensary shelves.

The pharmacy had a formal incident reporting procedure. And the electronic reporting tool was used effectively to capture learning outcomes and actions taken following a dispensing incident. For example, the pharmacy now had a dedicated work bench in the main dispensary which was used solely to bag assembled medicines. And all assembled medicines in this area remained in individual baskets with the appropriate prescription form.

The pharmacy had a complaints procedure. And it advertised how people could provide feedback or raise a concern through a notice in the public area of the pharmacy. The pharmacy also promoted feedback through its annual 'Community Pharmacy Patient Questionnaire'. It published the results of this questionnaire for people using the pharmacy to see. A pharmacy team member explained how she would manage a concern and escalate it on to a pharmacist. A pharmacist provided examples of how the pharmacy responded to feedback. For example, it had worked together with surgery teams to bring prescriptions for medicines started mid-cycle in line with other medication regimens. This helped people as it meant they received all their medicines at the same time each month.

The pharmacy had up-to-date indemnity insurance arrangements in place. The RP notice was updated as the inspection began to include the correct details of the RP on duty, this was shortly after opening time. Entries in the responsible pharmacist record generally complied with requirements, there was one missed sign-out time in the sample of the record examined. The pharmacy maintained running balances in its CD register. And it completed balance checks as CDs were received and supplied. It undertook some full balance checks of all CDs in the register against physical stock. But the last full balance check was recorded as taking place in January 2019. This meant that it could be more difficult for the pharmacy to manage a discrepancy should one occur. A physical balance check of MST Continus 5mg tablets complied with the balance recorded in the register. The register was maintained in accordance with legal requirements. The pharmacy recorded its private prescriptions both in a manual Prescription Only Medicine (POM) register and within an electronic register. The use of medicine labels to record some details within the manual register was discouraged. And the option to only hold one version of the register was discussed with a pharmacist. All required details were recorded within both registers. And full details of emergency supplies of medicines were kept electronically. The pharmacy kept specials records in accordance with the requirements of the Medicines & Healthcare products Regulatory Agency (MHRA).

The pharmacy stored people's personal information in staff only areas of the premises. And pharmacy team members demonstrated how their working processes kept people's information safe and secure. All team members had completed some learning relating to confidentiality requirements. The pharmacy had submitted its annual NHS Data Security and Protection toolkit as required. It disposed of confidential waste by using a number of shredders readily available throughout the pharmacy.

The pharmacy had procedures and information relating to safeguarding vulnerable people in place. And a pharmacist demonstrated a NHS safeguarding guide application on her smart phone. This provided up-to-date guidance and contact information for safeguarding teams. Pharmacists had completed level two safeguarding training through the Centre for Pharmacy Postgraduate Education (CPPE). And other members of the team had completed e-learning on the subject. Pharmacy team members demonstrated a sound understanding of how to recognise and report safeguarding concerns. They explained how they remained vigilant when providing services and would report any concerns in the first instance to a pharmacist. The pharmacy team provided examples of how it had shared some concerns with GP surgery teams.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough skilled and knowledgeable people working to provide its services safely. It monitors staffing levels and skill mix within the team. The pharmacy actively encourages feedback from its team members through regular performance and development reviews. It uses the feedback it receives to inform the safe management of its services. Pharmacy team members are encouraged to engage in continual learning relevant to their roles. And members of the team completing accredited training receive protected learning time. Pharmacy team members work well together and engage in discussions relating to risk management and safety.

Inspector's evidence

On duty at the time of the inspection was the RP, a second pharmacist, three qualified dispensers, a trainee dispenser and a delivery driver. The pharmacy also employed the superintendent pharmacist, another dispenser, a medicine counter assistant and a Saturday assistant. The superintendent pharmacist and two company directors covered the pharmacy's opening hours. Two pharmacists worked together across three of the pharmacy's busiest days each week. The medicine counter assistant also covered part of the prescription delivery service offered to people. A pharmacist confirmed the Saturday assistant was employed to assist with general sales only and did not undertake any tasks associated with managing or supplying medicines. Most pharmacy team members were full-time. And they could explain how they planned their workload to help manage annual leave and unplanned leave. The RP discussed some impacts of the government funding cuts to community pharmacy. One full-time member of the team, who had left the business recently had not been replaced due to the impact of these cuts. Pharmacists had increased the number of hours they put into the business as a result of this change.

The trainee dispenser was enrolled on an accredited training course. And a qualified dispenser was enrolled on a level three course in pharmacy services. Both members of the team received regular, protected training time to support them in their learning and development. And confirmed they felt supported and able to ask any questions relating to their learning. Other pharmacy team members confirmed they were supported in engaging in regular learning. This learning ranged from reading information in pharmaceutical journals to completing e-learning modules. And pharmacy team members could discuss how they had used information they had learnt to assist in managing their approach to high-risk medicines. For example, they were aware of the requirements of the valproate pregnancy prevention programme (PPP). And could discuss how they would recognise and refer a prescription for a person in the high-risk group to a pharmacist.

The pharmacy had a flexible approach to managing the performance and development of its team members. This involved informal day-to-day feedback. And structured one-to-ones. But appraisal records were not kept onsite for staff to refer to. It also supported the ongoing learning needs of other healthcare professionals. For example, it accommodated GP registrar placements to help support shared learning between the pharmacy and nearby surgeries. One of the pharmacists also worked as a practice pharmacist in the neighbouring surgery. The pharmacy applied care to ensure there was a clear distinction maintained between the pharmacist's surgery role and community pharmacy role. The role did allow him to act in the interests of people visiting the pharmacy as it meant he was able to answer

some queries relating to medications regimens without the need to refer a person back to their GP.

The pharmacy was busy throughout the inspection. Pharmacy team members were observed serving people in a timely manner and supporting each other. For example, those working in the back dispensary served on the medicine counter when queues started to form. The trainee dispenser spent most of his time supporting the managed repeat prescription services. And he identified how this helped him as it reduced the risk of pressure whilst in this training role. The pharmacy's directors met regularly to discuss how services were being delivered and to monitor the targets they had set for themselves. Both pharmacists on duty clearly had a passion for engaging with people about their health and wellbeing. And they discussed how they applied their professional judgement when providing services. And pharmacy team members supported pharmacists by identifying people who would benefit from a service during the dispensing process.

The pharmacy team communicated mainly through small informal briefings throughout the working day. And pharmacy team members explained how they contributed to these discussions. But the pharmacy didn't always record the outcomes of its discussions. This meant that staff not on duty at the time could potentially miss out on some shared learning opportunities. The pharmacy had a whistleblowing policy in place. And all pharmacy team members were provided with a copy of the pharmacy's employee handbook when commencing their roles. Pharmacy team members explained they were confident in sharing feedback or raising concerns if required and explained how they would do this. A dispenser demonstrated how the placement of some medicines in the main dispensary had changed following staff feedback about the risk of placing them on high shelves.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean, secure and maintained to the standards required. People using the pharmacy can speak with a member of the pharmacy team in confidence in a private consultation room.

Inspector's evidence

The pharmacy was located on a busy junction in the main shopping area of the town. The outside of the premises were traditional in appearance. Inside the pharmacy was professional and spacious. The pharmacy was secure and well maintained. Maintenance concerns were managed through local trades people. The public area was accessible to people using wheelchairs and pushchairs. It stocked healthcare products, medicines and a range of gifts. There was a clearly sign-posted consultation room. The room was a good size and professional in appearance. And pharmacy team members used the room with people requiring a private conversation throughout the inspection. For example, the RP used the room to deliver the flu vaccination service.

The staff only area of the pharmacy consisted of two dispensaries, staff facilities and a dedicated delivery room. An area to the side of the medicine counter was used to hold some of the pharmacies paperwork and provided an area to complete tasks associated with the pharmacy's free gift-wrapping service. The dispensaries were a good size for the level of activity taking place. The front dispensary was used to manage acute workflow. When there was a demand for the service, larger prescriptions were passed back into the second dispensary. This helped manage workload pressure effectively.

Work benches and floors were free from clutter. And the pharmacy was clean throughout. The pharmacy had suitable heating and air conditioning arrangements. Lighting throughout the premises was sufficient. Antibacterial soap was readily available at designated hand washing sinks, including at a sink in the consultation room.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's services are easily accessible to people. And the pharmacy has actively considered the possible barriers to people accessing some urgently required services out-of-hours. And it has taken steps to overcome these barriers and respond to the specific needs of the local community. The pharmacy has procedures to support its team members in delivering its services safely. And it has good records in place to support people who receive their medicines through its multi-compartmental compliance pack service. The pharmacy obtains its medicines from reputable sources. And it manages them appropriately to help make sure they are safe to use.

Inspector's evidence

The pharmacy was accessed through a power assisted door from street level. Details of its opening times and services were clearly advertised. An electronic scrolling notice advertised specific services. For example, the flu vaccination service. The pharmacy team members explained how they engaged people in discussions about their health and wellbeing through supporting national health campaigns. On the date of inspection, the pharmacy was swapping between two campaigns and as such did not have an active display. A member of the team discussed the popularity of a recent display focussed on dementia. And the pharmacy had a wide range of information leaflets available for people to take. Pharmacy team members engaged well with people by discussing their healthcare needs. Both pharmacists were observed speaking with people about their medicines. And the RP was observed taking people into the consultation room when delivering services. For example, the flu vaccination service. The pharmacy team members understood the requirements to signpost people to another pharmacy or healthcare provider if the pharmacy was unable to provide a service.

A pharmacist provided regular medicines management support to two care homes and a community hospice. This support had included training sessions for staff and talks at the hospice. The pharmacy were particularly good at protecting the dignity of people on palliative care regimens. The RP explained how he provided his telephone number to the carers of people who received their medicines through syringe drivers. And he was contactable to these people 24/7 in case of any concerns. The same service was also provided to the hospice. The RP explained this meant that palliative care medicines were always available and discussed examples of how this access had been used to support people.

The pharmacy had up-to-date patient group directions (PGDs) for the supply of varenicline tablets and emergency hormonal contraception (EHC). A pharmacist explained how people travelled from further afield to access smoking cessation advice and the supply of varenicline tablets. The pharmacy kept robust records for people accessing this service. It also supplied some medicines to people through a local minor ailments protocol (Pharmacy First). And pharmacy team members were knowledgeable about the inclusion criteria for the protocol.

The pharmacy had some processes in place for identifying and counselling people on high-risk medicines. Pharmacy team members highlighted assembled bags of medicines to inform referral to a pharmacist when required. The pharmacy team were aware of the requirements of the valproate pregnancy prevention programme (PPP) and the pharmacy displayed safety guidance associated with the isotretinoin PPP in its dispensary. The pharmacy had valproate warning cards available. The RP

discussed his practice-based role which had involved reviewing prescriptions for people in the high-risk group. Pharmacists verbally counselled people when supplying medicines, including high-risk medicines. They recorded some, but not all of their interventions.

The pharmacy used a schedule to help manage the supply of medicines in multi-compartmental compliance packs. And it used individual profile sheets which provided clear details of people's medication regimen. Pharmacy team members demonstrated how changes to medication regimens and conversations with surgery teams were comprehensively recorded on people's medication records. A sample of assembled packs contained full dispensing audit trails. The pharmacy provided descriptions of the medicines inside the pack to help people identify them. And it supplied patient information leaflets at the beginning of each four-week cycle of packs. Monthly supplies of medicines to two care homes were also made in multi-compartmental compliance packs following the same system. Medication administration record (MAR) sheets were provided to the care homes. And the homes re-ordered their prescriptions through the pharmacy. The team had created a timetable to assist in the management of the care home services. The pharmacy managed the supply of some multi-compartmental compliance packs weekly, this was due to the limited stability of some medicines when removed from their original packaging. It had appropriate resources for helping the team to identify and manage these medicines.

The pharmacy very infrequently prepared topical preparations on the premises. And this service had not been provided recently. It had the appropriate equipment available to support this process. And pharmacy team members had completed additional learning relevant to these tasks and followed procedures. The preparation was completed under the supervision of a pharmacist. And a full audit trail of the activity was maintained, with records kept identifying the batch numbers and expiry dates of the medicines used. But the pharmacy did not have a manufacturers Specials (MS) licence from the MHRA for this activity. If this activity was to continue the pharmacy should refer to the GPhC Guidance for registered pharmacies preparing unlicensed medicines to help it manage the risks associated with supplying medicines in this way.

The pharmacy used coloured baskets throughout the dispensing process. This kept medicines with the correct prescription form and helped inform workload priority. Pharmacy team members signed the 'dispensed by' and 'checked by' boxes on medicine labels to form a dispensing audit trail. The pharmacy team kept original prescriptions for medicines owing to people. The team used the prescription throughout the dispensing process when the medicine was later supplied. It issued dockets for all owed medicines. The pharmacy facilitated a repeat dispensing service through its electronic prescription service (EPS). And a pharmacist demonstrated how the team managed the risks associated with this service. For example, prescriptions received ahead of seven days prior to them being due were returned to the spine and only downloaded when due. The pharmacy had systems to identify changes to medication regimens for these prescriptions. And it communicated the need to book GP reviews with people through placing a note on the assembled medicine when the last prescription for each authorisation was dispensed.

The pharmacy's delivery driver contacted people prior to ordering prescriptions through the pharmacy's managed repeat prescription service. And the pharmacy kept audit trails to help it chase missing prescriptions and queries with surgery teams. The pharmacy also kept audit trails for the prescription delivery service and people signed to confirm they had received their medicine. The pharmacy had risk-assessed the delivery of cold-chain medicines. And it managed the delivery of these medicines by storing them in a cool box during warmer weather. A data tracker was put inside the box to help monitor the storage temperature of these medicines.

The pharmacy sourced medicines from licensed wholesalers and specials manufacturers. Pharmacy

team members were aware of the Falsified Medicines Directive (FMD) and demonstrated the processes they followed to decommission medicines. The pharmacy had adapted its dispensing processes to comply with FMD when dispensing medicines in packaging which met FMD requirements. The pharmacy stored Pharmacy (P) medicines behind the medicine counter. This meant the RP had supervision of sales taking place from their checking area. And they were able to intervene if necessary. The pharmacy stored medicines across both dispensaries and within the delivery room. Medicines storage was orderly. The pharmacy used a unique system to identify split-boxes of medicines. It did this by inserting a tongue depressor into each split pack. The system worked well to identify the split boxes and reduced the risk of the pharmacy supplying an incorrect quantity of medicine. The pharmacy had regular date-checking arrangements in place. And pharmacy team members were observed checking expiry dates during the dispensing process. They also annotated the opening date on to bottles of liquid medicines. This allowed them to apply checks during the dispensing process to ensure the medicine remained fit for purpose. Two bottles of liquid medicines which had gone beyond their shortened expiry date were removed from the stock shelves and brought directly to the attention of a pharmacist. A couple of out-of-date medicines were also found in the extemporaneous supply cupboard.

The pharmacy held CDs in secure cabinets. Medicines were kept in a safe and orderly manner inside both cabinets. There was designated space for storing patient returns, and out-of-date CDs. The pharmacy marked all CD prescriptions which prompted additional checks of these high-risk medicines. And assembled CDs were stored in clear bags within a cabinet. Split boxes of CDs were identified by using the tongue depressors. And blister strips inside these split boxes were physically attached to the depressor to avoid any risk of them falling out of their original packaging. The pharmacy used two fridges to store medicines. One held stock and the other assembled medicines and some stock lines such as flu vaccinations. Storage arrangements in both fridges were organised. Assembled medicines were stored in clear bags which prompted additional checks prior to handing out the medicine. Temperature records confirmed the fridges were operating between two and eight degrees Celsius as required. The pharmacy had data trackers in both fridges, this helped the pharmacy apply additional monitoring checks should the temperature on the thermometer be outside of the required range.

The pharmacy had medical waste bins, sharps bins and CD denaturing kits available to support the team in managing pharmaceutical waste. The pharmacy received drug alerts through email. And the superintendent pharmacist shared these with the team. Pharmacy team members discussed how they checked these alerts.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs for providing its services. It regularly monitors its equipment to help provide assurance that it is in safe working order. And pharmacy team members manage and use equipment in a way which protects people's confidentiality.

Inspector's evidence

The pharmacy had up-to-date written reference resources available. These included the British National Formulary (BNF) and BNF for Children alongside other clinical reference books. Pharmacy team members also had access to the internet which provided them with further resources. The pharmacy's computers were password protected and information on computer monitors was protected from unauthorised view due to the layout of the pharmacy. The RP discussed how particular care was taken when showing a person information displayed on a monitor in the pharmacy's consultation room. The pharmacy held assembled bags of medicines within the dispensaries. This protected people's private information on prescriptions and bag labels from unauthorised view. Pharmacy team members used NHS smart cards to access people's medication records. And they used cordless telephone handsets. They physically moved out of earshot of the public area when discussing confidential information over the telephone.

The pharmacy stored some equipment for its services such as a battery-operated blood pressure machine, sphygmomanometer and anaphylactic treatment supplies in its consultation room. But the public facing door to the room was not kept locked between use. The pharmacy also had a defibrillator in its consultation room. And this was labelled to confirm it had been checked to ensure it remained fit for purpose. A discussion took place about the benefits of protecting this equipment and any information in the room from any risk of unauthorised access. The pharmacy had clean, crown stamped measuring cylinders for measuring liquid medicines. And clean counting equipment for tablets and capsules. It monitored its equipment between use. For example, electrical equipment was safety tested. And a set of dispensary scales were calibrated prior to use. The pharmacy had the necessary equipment readily available to support the supply of medicines in multi-compartmental compliance packs. This included a machine which de-foiled medicines from blister packs and the team had access to gloves.

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.