General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Beacon Pharmacy, Skegness Road, Ingoldmells, SKEGNESS, Lincolnshire, PE25 1JL

Pharmacy reference: 1116173

Type of pharmacy: Community

Date of inspection: 15/11/2021

Pharmacy context

The pharmacy is in the grounds of a medical centre in the coastal town of Ingoldmells, Lincolnshire. It is open extended hours, including late into the evening seven days a week. And it serves both local residents and tourists during the busy holiday season. The pharmacy's main services include dispensing NHS prescriptions and selling over-the counter medicines. It delivers a high proportion of dispensed medicines to people's homes. And it also supplies some medicines in multi-compartment compliance packs, designed to help people to take their medicines. The pharmacy was inspected during the COVID-19 pandemic.

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 not all met	1.1	Standard not met	The pharmacy does not routinely assess the key risks to its services. There is evidence that team members do not always work in accordance with the pharmacy's procedures, creating risk. The pharmacy does not keep some pharmacy records in accordance with legal and regulatory requirements. And there is evidence that its processes for embedding learning from mistakes is not effective. This has led the team to make related serious mistakes on more than one occasion.
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 not all met**

Summary findings

The pharmacy doesn't routinely identify key risks to patient safety. There is evidence that written procedures designed to support the safe and effective running of the pharmacy are not always followed. This includes the completion and maintenance of some pharmacy records required by law. And following processes designed to support routine monitoring checks. The pharmacy's approach to sharing learning and reducing risk is not as effective as it should be. This is because a similar thing has gone wrong more than once. The pharmacy has adequate processes in place to manage feedback about its services. It protects people's private information. And its team members understand how to help safeguard potentially vulnerable people.

Inspector's evidence

The pharmacy had appropriately addressed the risks of managing its services during the COVID-19 pandemic. This included fitting a plastic screen at the medicine counter and holding discussions with team members to help identify their own personal risks. Pharmacy team members could generally socially distance when working. Most team members donned type IIR face masks at all times, and some wore them when in close proximity to others. The pharmacy team had supplies of other personal protective equipment (PPE) available if needed. The pharmacy team had access to standard operating procedures (SOPs) associated with managing risk during the pandemic. And information displayed in the dispensary highlighted the type of PPE to be worn across different healthcare settings.

The pharmacy had a range of SOPs to support the safe running of the pharmacy. A team member demonstrated how these were accessible electronically by doing a search on the company's shared drive. The SOPs covered responsible pharmacist (RP) requirements, controlled drug (CD) management, dispensing processes, and pharmacy services. And they were up-to-date and relevant to the services provided. But team members on duty did not know where the pharmacy held training records associated with the procedures. A senior team member explained that new inductees received time during induction training to read and sign the procedures. Team members on duty demonstrated and explained how they managed tasks associated with their roles. For example, one team member explained what tasks the team couldn't complete if the RP was absent from the premises. And another team member explained how requests for some Pharmacy (P) medicines required the direct intervention of the pharmacist. There was evidence of team members carrying out some tasks differently to the written process described in SOPs. For example, team members did not always follow the requirements of the SOP for assembling medicines in multi-compartment compliance packs, a high-risk activity. And SOPs designed to identify and manage risk were not regularly followed. For example, the team only recorded temperatures in two of the pharmacy's three fridges. This was despite procedures highlighting the importance of checking fridge temperatures when the RP assumed the role of the responsible pharmacist. And it was not evident which two fridges the record related to. There was also a risk that different pharmacists checked the temperature of different fridges as no fridges were clearly identified in the record.

Pharmacy team members engaged in some processes designed to reduce risk. But these were limited. And there was little evidence of continual learning. For example, team members pointed out each other's mistakes during the dispensing process to help prompt awareness and reduce the risk of similar

mistakes occurring. But there was no measure of how effective this process was as there were large gaps in the actual recording of these near misses. This severely limited the pharmacy's ability to share learning following a near miss being made. The pharmacy had an incident reporting process in place to aid the investigation of dispensing incidents. Team members were aware of the need to report incidents. But there was no evidence of incident reporting available. This was due to the team members on duty being unaware of how to access the system. A team member explained that discussions took place when risks were identified. And went on to highlight a discussion around the importance of checking medicines before placing them back into split packs. This discussion had taken place following a stock box of medicine being found to contain a different high-risk medicine when a team member was assembling a prescription. But following the inspection it was evident that the learning in this instance had not been taken onboard by the team. This was because an internal investigation into a CD balance discrepancy highlighted during the inspection visit found the cause to be down to two 30mg capsules found inside a box of 60mg capsules of the same medicine. The senior pharmacy technician providing feedback about the internal investigation had also found several more discrepancies in the CD register which required further investigation.

The pharmacy maintained its CD register with running balances. But despite a notice explaining balance checks should take place weekly there was often several months between balance checks. This meant it could be more difficult for the pharmacy to investigate a concern if one arose. Three random balance checks completed during the inspection found one of the three did not comply with the balance recorded in the CD register. And an internal investigation followed. A discussion took place about the importance of reporting any unresolved balance discrepancies to the NHS CD accountable officer. The pharmacy had a patient returned CD destruction register. But it did not always enter details of returns at the point of receipt.

The pharmacy had up-to-date indemnity insurance arrangements in place. The RP notice displayed was changed at the beginning of the inspection to display the correct details of the RP on duty. The pharmacy had three RP records in operation instead of the one record legally required. These consisted of two hand-written records and an electronic record. But no record complied with RP regulation as different pharmacists were using different records. The pharmacy team could not locate the private prescription register during the inspection. But could provide access to an electronic register. The pharmacy generally kept the electronic register in accordance with legal requirements. But team members did not accurately record the details of the prescriber when making a record of a private prescription. Some prescriptions associated with records held in the electronic private prescription record were not available for inspection. The pharmacy dispensed some private prescriptions for isotretinoin and it had made at least one of these supplies against a photocopy. All private prescriptions seen for this medicine did indicate a negative pregnancy test result. But there was a lack of awareness about the timescales associated with supplying this medicine within seven days of the prescription date. And there was no evidence of a process in place to ensure the original prescription was obtained in a timely manner following the decision to supply against a copy. The pharmacy held its specials records in accordance with the requirements of the Medicines and Healthcare products Regulatory Agency.

The pharmacy advertised its complaints procedure and its privacy notice to people. A team member provided an example of how they would manage a concern. And included the need to establish the person's expectations of how their concern would be managed. And when to refer to a senior team member for support. The pharmacy had information governance procedures to support its team members in managing people's private information securely. And team members on duty were observed managing people's information with care. The pharmacy stored most personal identifiable information in staff-only areas of the premises. Some information was stored in the consultation room,

but this was not in the direct view of members of the public using the room. And the room could only be accessed from beyond the medicine counter. The pharmacy held confidential waste in baskets at workstations across the dispensary. The team then transferred the contents of the baskets to white sacks held in the stock room. But the pharmacy did not currently receive a regular collection of this waste as it was in the process of setting up a contract. A team member explained that a shredder had been provided on occasion when waste had built-up.

The pharmacy had procedures relating to safeguarding vulnerable adults and children. And contact information for local safeguarding agencies was available. The RP on duty had completed safeguarding training through the Centre for Pharmacy Postgraduate Education. And other members of the team demonstrated an understanding of how to recognise and report a safeguarding concern. A team member demonstrated recent actions taken to safeguard a person suffering from dementia.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy employs a relatively small team for the high volume of work it manages. Its team members work well together to manage this workload. And they proactively plan how they will manage the workload during periods of reduced staffing. Pharmacy team members are confident in providing feedback and know how to raise a professional concern if needed. But they do not always have the opportunity to engage in structured meetings to help share learning and monitor risk.

Inspector's evidence

The pharmacy team on duty consisted of the RP, three trainee dispensers, two qualified dispensers (one of whom was the assistant manager) and a delivery driver. The pharmacy also employed an accuracy checking technician, who was the pharmacy manager, a pre-registration trainee pharmacy technician, two qualified dispensers and additional drivers. There was no regular full-time employed pharmacist in post. But a pharmacist director and regular locums generally worked across the pharmacy's extended opening hours. The team did express that pharmacist cover had been extremely difficult to find during periods of the pandemic. This had resulted in some unexpected closures. And a senior team member explained how the pharmacy had followed NHS England's reporting process when the pharmacy had needed to close due to no pharmacist availability. A senior pharmacy technician working in an area role was also at the premises during the inspection. Team members generally worked to cover each other's leave. And the pharmacy was in the process of recruiting a temporary team member to cover some forthcoming long-term planned leave of one if its team members. Workload on the day of inspection was seen to be well managed and was up to date. And due to annual leave within the team there was a focus on providing essential NHS services. A team member was observed signposting a member of the public to another pharmacy for the NHS flu vaccination service.

Trainee dispensers explained that they felt supported in their roles. And they were confident in asking questions and in seeking out information to support each other. One trainee had received an extension to their contract after being employed on a temporary contract following joining the team under the government's Kickstart scheme. The pharmacy did not provide protected training time at work for its team members. But a trainee explained that they could take time during quieter periods. All team members engaged in ongoing training relevant to their role. This had focussed heavily on the training requirements set out within the NHS Pharmacy Quality Scheme within the last few years.

The RP confirmed that the pharmacy did not set specific targets relating to services to his knowledge. And he worked at the pharmacy regularly. Pharmacy team members were confident when explaining how they could provide feedback or share ideas at work. And they had an awareness of how to escalate a concern at work. But the pharmacy did not support its team members through a regular structured appraisal process. And although the team held regular discussions to share information, it did not record the details of these discussions. This meant that the opportunity to share learning and measure the impact of any agreed actions during these discussions may be limited.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are safe and secure. They provide a suitable space for the delivery of pharmacy services. But clutter in some parts of the premises may prevent some of the facilities such as the consultation room from being fully utilised by members of the public.

Inspector's evidence

The public area of the pharmacy was small. It provided seating for people waiting for their prescriptions of for a service. And it stocked a small number of health-related products. A gate at the counter deterred unauthorised access through to the dispensary. The pharmacy's consultation room was beyond this gate. As such every person using the room was escorted. The room was a good size but it was extremely cluttered with large boxes containing stock medicines and paperwork. This distracted from the overall professional appearance of the pharmacy.

The dispensary was an adequate size for the services provided. Workflow was well established with some shelving used to hold baskets off bench level. For example, to hold part-assembled prescriptions waiting for stock. But the pharmacy team also stacked some baskets with medicines in them at floor level in the dispensary and within the multi-compartment compliance pack dispensing room. This was not ideal, but care was taken to place the baskets away from walkways and the medicines inside were yet to be assembled. To the back of the dispensary was another small room. The room provided space for managing tasks associated with the supply of multi-compartment compliance packs. A staff kitchen and toilet facilities were also accessed off the dispensary. A storeroom at the back of the pharmacy was cluttered with medicine waste and confidential waste.

The premises were secure and maintained to an appropriate standard. They were clean with cleaning tasks split between team members and an employed cleaner. Lighting was bright throughout the premises. Heating and air conditioning was in working order. And a team member explained the air conditioning unit had very recently been serviced. Antibacterial soap and paper towels were available at sinks throughout the pharmacy.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy makes its services accessible to people over extended hours. On occasions when it is unable to provide a service or supply a medicine the team appropriately signposts people to other healthcare providers. The pharmacy obtains its medicines from reputable sources. And it generally stores its medicines safely and securely. Team members do not always follow the pharmacy's written procedures when providing medicines in multi-compartment compliance packs. So, they cannot be sure they always work in the safest and most effective way.

Inspector's evidence

The pharmacy was accessible through an automatic door up a ramp from the car park. It advertised details of its opening hours and services clearly for people to see. Team members understood how to signpost a person to another pharmacy or healthcare professional when the pharmacy was unable to provide a service or supply a medicine. The pharmacy protected P medicines from self-selection by displaying them behind the medicine counter. And the RP was able to supervise activity in the public area from the dispensary.

There were some processes in place for managing higher risk medicines. The pharmacy clearly highlighted valproate preparations on the dispensary shelves. And it had resources associated with the valproate pregnancy prevention programme (PPP) to hand. These included patient cards and guides. The RP discussed how he would manage a prescription for valproate for a person within the high-risk group. And details of his approach was in accordance with the requirements of the PPP. The RP demonstrated 'INR' stickers which were used to identify the need to refer a person to the pharmacist for additional counselling when warfarin was dispensed. Any checks associated with counselling for these higher risk medicines was verbal, and was not recorded on the patient medication record (PMR) system.

The pharmacy kept each person's prescription separate throughout the dispensing process by using baskets. And team members brought prescriptions belonging to people waiting in the public area, to the direct attention of the RP. The pharmacy held part-assembled medicines and prescriptions in baskets on designated shelving. And this system identified if the medicine required delivering or sending to a collection point. The pharmacy also retained prescriptions for owed medicines, and team members dispensed from the prescription when later supplying the owed medicine. The pharmacy kept an audit trail of each person it delivered medicine to. It delivered some medicines to two collection points within local surgeries. This provided people with the option of collecting their medicine from the surgery and not the pharmacy. The suitability of the medicine being sent to a collection point was assessed. For example, this was not an option for CDs. Where this arrangement was in place the pharmacy provided a note within the bag of medicine if additional counselling was required, and it made its telephone number available to people. The surgery team returned an audit sheet confirming the collection of these medicines.

Pharmacy team members signed the 'dispensed by' and 'checked by' boxes on medicine labels to form a dispensing audit trail. The pharmacy's system for supplying medicines in compliance packs was managed through the pharmacy's PMR software. And changes to medicine regimes and queries were recorded within the PMR. But the inspection identified that the system did not provide adverse warning

labels on the backing sheets attached to assembled compliance packs. A team member immediately acted on this feedback by contacting the software provider. And this issue was rectified. One team member was the lead for the service and another team member supported this role. Other team members also supported the service. For example, by picking medicines ready for assembly into compliance packs. A sample of assembled packs included full dispensing audit trails and descriptions of the medicines inside to help people recognise them. A team member demonstrated how a separate 'dispensing sheet' (a copy of the backing sheet) was used to ensure descriptions of medicines inside the packs were kept up to date. The pharmacy generally provided patient information leaflets at the beginning of each four-week cycle of packs. At the time of inspection, the pharmacy had pre-assembled a number of packs ahead of it receiving the prescriptions. The process in place considered the risks involved in this practice. Team members used an individual patient-picking sheet to pick the medicines. And this sheet was cross checked against the backing sheet and PMR. And all packs assembled in this way were identifiable and did not proceed to the final accuracy checking stage of the dispensing process prior to checks of the backing sheet, picking list and prescription being completed. But no risk assessment of the process had been undertaken. And the practice was not in accordance with the pharmacy's SOPs. A team member explained that this practice occurred during busier periods, such as the run up to Christmas.

The pharmacy sourced medicines from licensed wholesalers. It stored medicines in their original packaging in an orderly manner throughout the dispensary. The pharmacy stored medicines subject to safe custody arrangements appropriately in a secure cabinet. But the cabinet was at capacity and as such the storage arrangements needed reviewing. The storage conditions were thought to have contributed to the balance discrepancy identified during the inspection. And out-of-date CDs within the cabinet also impacted heavily on space. A discussion took place about the requirement to request an authorised witness visit to the pharmacy to destroy the out-of-date CDs securely. The pharmacy's fridges were clean and a good size for stock held. Fridge thermometers on the day of inspection all read between two and eight degrees Celsius as required. The pharmacy held assembled cold chain medicines and CDs in clear bags. And this helped prompt additional safety checks prior to handout.

The pharmacy had a date checking matrix which indicated that the most recent checks had been completed in May 2021. Team members were aware that checks were due and explained how they managed the risk of dispensing an out-of-date medicine by routinely checking expiry dates during the dispensing process. This practice was observed throughout the inspection. A random check of dispensary stock found no out-of-date medicines. And short-dated medicines were highlighted. The pharmacy had medicinal waste bins and CD denaturing kits available. A team member demonstrated how the team received medicine alerts by email. And team members checked for new email regularly to ensure they acted upon alerts in a timely manner.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs to provide its services. It maintains its equipment appropriately. And its team members generally act with care by using the equipment in a way which protects people's confidentiality.

Inspector's evidence

The pharmacy had up-to-date written and electronic reference resources available. These included the British National Formulary (BNF) and BNF for children. The pharmacy team used crown-stamped measuring cylinders for measuring liquid medicines. And it used separate equipment for measuring higher risk liquid medicines. Counting equipment was available for tablets and capsules. Equipment used to support the multi-compartment compliance pack service was single use.

The pharmacy's computer was password protected. And it was accessible to team members only. But during the inspection it was noted that one computer terminal was operating with one of the pharmacy director's NHS smart cards. This team member was not on duty. This was brought to the attention of a senior team member. And the card was removed immediately and stored securely. The pharmacy held bags of assembled medicines on shelves within the dispensary. This kept people's information out-of-view of the public area. Pharmacy team members used cordless telephone handsets. This allowed them to move out of earshot of the public area when a phone call required privacy.

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.