General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Ancora Healthcare Limited, 291 Ashby Road, SCUNTHORPE, South Humberside, DN16 2AB

Pharmacy reference: 1116386

Type of pharmacy: Community

Date of inspection: 09/01/2020

Pharmacy context

This community pharmacy is in the same building as a surgery on a main road leading into Scunthorpe, North Lincolnshire. It is open seven days a week and late into the evening. The pharmacy sells over-the-counter medicines and it dispenses NHS and private prescriptions. It offers advice on the management of minor illnesses and long-term conditions. It supplies some people with medicines in multi-compartment compliance packs, designed to help them remember to take their medicines. The pharmacy also provides a medicines delivery service to people's homes.

Overall inspection outcome

✔ **Standards met**

Required Action: None

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

Summary of notable practice for each principle

Principle	Principle finding	Exception standard reference	Notable practice	Why
1. Governance	Standards met	N/A	N/A	N/A
2. Staff	Standards met	N/A	N/A	N/A
3. Premises	Standards met	N/A	N/A	N/A
4. Services, including medicines management	Standards met	N/A	N/A	N/A
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance ✔ Standards met

Summary findings

The pharmacy identifies and manages the risks associated with its services. It generally maintains its records as required by law. It keeps people's private information secure. And it responds appropriately to feedback it receives about its services. Pharmacy team members act openly and honestly by sharing information when mistakes happen. And they show how they act to share learning and reduce risk following adverse events. They have the skills and knowledge required to protect the safety and wellbeing of vulnerable people.

Inspector's evidence

The pharmacy had a set of standard operating procedures (SOPs). The SOPs covered responsible pharmacist (RP) arrangements, controlled drug (CD) management, and services. These were in the final stages of review by the current superintendent pharmacist. Dates on SOPs confirmed the review process had started in autumn 2019. The SOPs contained details of the roles and responsibilities of pharmacy team members. But not all pharmacy team members had signed SOPs which had been reviewed several months ago. This meant that they may be unaware of any changes applied during the latest review. A dispenser explained clearly what tasks she could not complete if the RP took absence from the premises. And an accuracy checking pharmacy technician (ACT) explained how she checked repeat prescriptions only. Not all prescriptions checked by the ACT were marked to confirm a clinical check by a pharmacist had taken place. The pharmacy's dispensing team followed a process of recording new medicines and changes on prescription forms during the dispensing process. The ACT had access to the person's medication record to support her checking process. And the ACT explained how she would pass any prescriptions which required clinically checking to a pharmacist.

Workflow across the dispensary was efficient. Pharmacy team members demonstrated how they worked to manage their workload over the extended opening hours. There was separate space for labelling, assembling and accuracy checking medicines. And space at the back of the dispensary was provided for completing tasks associated with the supply of medicines in multi-compartment compliance packs. A dedicated area to the side of the dispensary provided protected space for managing the substance misuse services. And the pharmacy's supervisor demonstrated how information transcribed from prescription forms to the MethaMeasure system was checked by a pharmacist. An audit trail was in place to support this process. The pharmacy stored people's prescriptions in individual coloured folders. And people were asked what colour folder their prescription was stored in during the dispensing process. This improved efficiency when locating records. People with similar names were put into different coloured folders to help reduce the risk of selecting the wrong record. Every person on the supervised consumption service had their photograph linked to their MethaMeasure record. And biometric identification through a finger print scan was used for some people. But the supervisor explained the scanning equipment was not suitable for use with everyone and as such the photographic identification checks were used more frequently.

Pharmacy team members could explain how a pharmacist or the ACT would record details of near misses during the dispensing process. They were informed of their mistakes and took action to correct their own mistakes whenever possible. The records in place had some gaps in recording and a team member confirmed that in busy periods it could be more difficult to ensure a near miss was recorded.

The records provided some details of the near misses occurring. For example, the medication involved. But they did not regularly include other details such as contributory factors. A discussion took place about the advantages of involving pharmacy team members when recording near-miss errors. And in asking them to identify why the mistake was made. Pharmacy team members explained the superintendent pharmacist had completed an annual review of the types of mistakes being made in the pharmacy. And this review had been used to share learning. For example, by identifying commonly used 'look-alike and sound-alike' (LASA) medicines.

The pharmacy had an incident reporting process. This involved reporting directly onto the persons medication record. And then transferring the information to 'Pharmapod'. Pharmapod entries were reviewed by the superintendent pharmacist to help identify further learning and risk reduction actions. Pharmacy team members explained learning was shared in meetings and newsletters following these types of mistakes. For example, the team's attention had recently been drawn to the different formulations of a topical medicine following an incident. And a notice reminded pharmacists to ensure split boxes of buprenorphine tablets were used first to help reduce the risk of a quantity error occurring.

The pharmacy had a complaints procedure in place. It advertised how people could provide feedback or raise a concern about the pharmacy in its practice leaflet. Several pharmacy team members explained how they would manage feedback and escalate concerns to either the supervisor or RP, depending upon the nature of the concern raised. A team member explained how the timing of the afternoon prescription delivery service had been brought forward following feedback from some people about the lateness of some deliveries during winter evenings. The pharmacy also engaged people in feedback through an annual 'Community Pharmacy Patient Questionnaire'.

The pharmacy had up-to-date indemnity insurance arrangements in place through Numark. Details on the RP notice were kept up to date and accurate during the inspection. Entries in the responsible pharmacist record were generally completed in accordance with requirements. But there were a few missed sign-out times observed in the sample of the record examined. Samples of specials records complied with the requirements of the Medicine & Healthcare products Regulatory Agency (MHRA). The pharmacy kept its Prescription Only Medicine (POM) register electronically. Some prescription dates within the record did not match that of the accompanying prescription.

The pharmacy maintained its CD register electronically. A sample of the register examined found it generally complied with legal requirements. But an entry within the methadone section of the register made on 04 January 2020 did not include the name and address of the wholesaler who had supplied the methadone. The pharmacy maintained running balances within the register. And it generally completed weekly physical balance checks across all its CDs against the register. A physical balance check of MST Continus 30mg tablets complied with the balance recorded in the register.

The pharmacy displayed a privacy notice. It had up-to-date information governance procedures which included evidence of learning associated with the General Data Protection Regulation (GDPR). All pharmacy team members were required to complete this learning. The pharmacy had submitted its annual NHS Data Security and Protection (DSP) Toolkit annually as required. It stored all personal identifiable information in staff only areas of the pharmacy. And it had white sacks available for collecting confidential waste. These sacks were sealed by pharmacy team members and collected by a waste management contractor for secure disposal at periodic intervals.

The pharmacy had procedures and information relating to safeguarding vulnerable adults and children. But not all pharmacy team members had signed to confirm they had read and understood this

information. And one team member was not clear of the details of the SOP. But team members on duty provided evidence of the pharmacy acting on potential safeguarding concerns to protect vulnerable. It had done this by sharing concerns with the surgery team. And putting in place support tools to assist people in accessing their medicines. For example, supplying medicines in multi-compartment compliance packs. Pharmacy team members had access to contact details for local safeguarding agencies should they need to use them.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough skilled and knowledgeable people working to provide its services safely. It reviews its staffing levels and the skill mix of its team to ensure they remain appropriate. The pharmacy has appropriate feedback processes in place to support its team members in raising concerns if required. And its team members can provide examples of how the pharmacy uses their feedback to help manage pharmacy services. Pharmacy team members are generally enthusiastic about their roles and they understand the importance of sharing learning to improve safety across the pharmacy. They receive protected learning time and structured appraisals to support their continual development.

Inspector's evidence

The pharmacy employed two full-time regular pharmacists, with one pharmacist on duty at any given time. There had been some recent changes to pharmacist cover as a pharmacist on long-term leave had resigned and the superintendent pharmacist was due to stepdown from his role. The pharmacy's non-clinical manager confirmed recruitment for a new superintendent pharmacist had begun. And the pharmacy used regular locums to help provide cover over the extended opening hours.

Both full-time pharmacists contributed to the inspection process. On duty in the pharmacy alongside the pharmacists during the inspection was an ACT, a pharmacy technician (the pharmacy's supervisor), three qualified dispensers, a trainee medicine counter assistant and two delivery drivers. The pharmacy's non-clinical manager held a dual role between the pharmacy and surgery. He was available to support the team during the inspection process. In addition to the team members on duty, the pharmacy employed another qualified dispenser, two more trainee medicine counter assistants, a relief driver and a new member of staff who had recently begun his induction training.

Pharmacy team members received protected learning time. A planner was in place to assist them in ensuring they took this time. And a member of the team explained how she used the time to complete reading associated with SOPs and monthly update modules relating to over the counter medicines and common ailments. But some members of the team had yet to sign to confirm they had read and understood some of the updated SOPs from autumn 2019. A trainee medicine counter assistant explained she felt well supported by her colleagues. Team members enrolled on accredited training courses received additional time in work to support them in completing their courses. The pharmacy's supervisor was enrolled on an accuracy checking course. And provisions had been made to support him in completing the course ahead of the pharmacy's ACT taking planned long-term leave. The pharmacy had reviewed its skill-mix and had acted to recruit a temporary dispenser to cover this leave.

The pharmacy was busy throughout the inspection. Pharmacy team members were observed working well together. They checked people's names and addresses as they handed out assembled medicines. And they referred requests for additional information to a pharmacist appropriately. But there was some confusion over the tasks which could be completed by trainee medicine counter assistants. For example, trainee medicine counter assistants assisted in putting away the dispensary stock order. A discussion took place about the GPhC's guidance on the minimum training requirements for staff working in the dispensary. Following this conversation members of the dispensary team took over completing this task. The supervisor confirmed the trainees would not undertake this activity moving

forward.

The pharmacy set some targets associated with its services. And progress towards meeting these targets was shared with team members through a monthly newsletter. The newsletter also updated pharmacy team members on key information about services and some information related to patient safety. For example, learning from incidents. The supervisor explained this method of communication was being trialled for a few months and was due to be reviewed. Previously the team had held structured meetings to discuss this information. But there had been some feedback about this method of communication as not all team members could be present at the meeting. The current method of feedback involved team members signing to confirm they had received and read newsletters. And informal conversations and shared learning amongst the team was encouraged. The supervisor explained a staff meeting set for 12 February 2020 would review team members preferred method of communication moving forward.

The pharmacy had a whistle blowing policy. Most members of the team spoken to about feedback processes were confident in explaining how they would raise and escalate a concern. One member of the team was not clear on how feedback could be escalated through the whistleblowing policy if required. There were some positive examples of how the pharmacy had responded to feedback demonstrated. For example, the dispenser managing the multi-compartment compliance pack service had introduced some positive changes to the way workload for the service was managed.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is secure and maintained to the standards required. People using the pharmacy have the option to speak to a member of the team in confidence in a private consultation room.

Inspector's evidence

The pharmacy was professional in appearance and it was secure. The public area was open plan. It was accessible to people using wheelchairs and pushchairs. And it had seating provided for people waiting for prescriptions or services. The pharmacy was air conditioned and lighting throughout was sufficient. The premises were well maintained. Pharmacy team members explained they would report maintenance issues in the first instance to the supervisor or manager.

To the side of the public area were two signposted consultation rooms. One room was used for providing consultation services such as Medicines Use Reviews (MURs). And the second room provided confidentiality to people accessing substance misuse services. The second room led to a hatch at the side of the dispensary. Both rooms provided a suitable environment for speaking to people about their medicines and health. A semi-private ‘prescription’ window to the side of the dispensary provided further space to hold some conversations with people about their medicines.

The dispensary was an adequate size for the level of activity taking place. Pharmacy team members demonstrated how they managed space over the extended opening hours. For example, there was a focus on managing acute prescriptions during the busiest hours and repeat prescriptions when the acute service eased. There was enough space for labelling, assembling and accuracy checking medicines in the front section of the dispensary. A small work bench to the side of the dispensary was used for managing administration tasks and putting away the stock order. To the back of the dispensary was another work bench which was primarily used for tasks associated with the multi-compartment compliance pack service. A staff toilet was accessible off the back of the dispensary.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's services are easily accessible to people. It obtains its medicines from reputable sources. And it has appropriate systems in place to ensure it keeps these medicines safe and secure. The pharmacy has procedures to support its team members in managing its services safely. The pharmacy team members follow these procedures. And people visiting the pharmacy receive advice and information to help them take their medicine safely.

Inspector's evidence

The pharmacy was fully accessible through an open plan entrance within the building. Access into the building was from a ramp with handrails which led from the surgery car park. The pharmacy advertised details of its opening times and services clearly. Further information relating to health campaigns and services was available in the public area. Pharmacy team members understood the requirement to signpost people on to another healthcare provider or pharmacy, should the pharmacy not be able to provide a service or a medicine.

Pharmacy team members explained how they supported pharmacists in identifying eligibility for services such as Medicines use reviews (MURs) and New Medicine Service (NMS) consultations during the dispensing process. And pharmacist shared examples of positive outcomes from the services provided. For example, advising on the correct way to reduce an antidepressant by encouraging discussion with their own GP. And advice about the safe use of over-the-counter medicines. A pharmacist provided several examples of how the Community Pharmacist Consultation Service (CPCS) had supported people in obtaining urgently required medicines when their surgery was closed. The pharmacy had put a support tool in place for one person to help them in monitoring their condition when changing their medication regimen.

The pharmacy stored Pharmacy medicines behind the medicine counter. This meant the RP had supervision of sales taking place and was able to intervene if necessary. Pharmacy team members were asked to request a person's details when selling co-codamol preparations. Pharmacists explained this was due to some concerns relating to the over-use of over-the-counter painkillers licensed for sale for short term use only. And the process allowed the pharmacy to monitor the safe usage of the medicine by recording sales on people's medication records. And if necessary refer the person to their GP for a full assessment of their pain. Pharmacists expressed how the process helped them apply their professional judgement when approving sales. And explained how they would take all information into account when authorising a sale of co-codamol if a person did not wish to provide these details.

The pharmacy had some processes for managing high-risk medicines. For example, it clearly marked prescriptions for controlled drugs. And pharmacists explained how they verbally counselled people when handing out higher-risk medication requiring regular monitoring. A pharmacist explained how people taking these medicines were invited for MURs. The pharmacy was engaging in audits relating to the supply of some high-risk medicines. These audits helped to provide assurance that people were aware of the side-effects of their medicines and the ongoing monitoring required. Pharmacy team members could discuss the requirements of the valproate Pregnancy Prevention Programme (PPP). And understood the requirement to issue high-risk warning cards to people in the at-risk group when

supplying valproate.

The pharmacy ordered prescriptions for people receiving their medicines in multi-compartment compliance packs. And a dispenser demonstrated the checks she made to help identify any changes to medication regimens. These included some improved processes by recording tracked details of changes on individual records associated with the service. The pharmacy used a tracker to help manage and monitor workload associated with the service. And this was seen to be completed routinely. This supported pharmacy team members in managing queries associated with the service should one arise. A sample of assembled packs contained simple descriptions of the medicines inside to help people identify them. And patient information leaflets were seen to be provided at the beginning of each four-week cycle of packs. But there was not a full dispensing audit trail on assembled packs. The pharmacist or ACT did sign to confirm they had accuracy checked the pack. But dispensers did not routinely sign to confirm assembly. And backing sheets were not physically attached to packs. This meant labelling requirements were not met and there was a risk of the information on the backing sheet not being kept with the pack once supplied to a person. Common practice used for attaching backing sheets to both single-use multi-compartment compliance packs and Pivotell devices was shared with the dispenser. And the dispenser demonstrated how this feedback was taken onboard and used to inform improvements during the inspection. The pharmacy did not always consider the risks associated with supplying medicines designed to be kept in their original packaging through the multi-compartment compliance pack service. These medicines were not commonly supplied in multi-compartment compliance packs. And a pharmacist confirmed any supply of these medicines through the service would be reviewed following these risks being highlighted.

The pharmacy used 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. And it used the prescription throughout the dispensing process when the medicine was later supplied. The pharmacy retained an audit trail for its prescription delivery service. And people were asked to sign for receipt of their medicines through this service.

The pharmacy sourced medicines from licensed wholesalers and specials manufacturers. Pharmacy team members discussed changes to medicine packaging introduced due to the Falsified Medicine Directive (FMD). The pharmacy was registered with SecurMed and it had scanners ready to support it in complying with FMD requirements. But pharmacy team members confirmed they were waiting on changes promised by the pharmacy’s clinical software programme provider before it could begin scanning medicines. The pharmacy team received medicine safety alerts and drug recalls by email. And it maintained an audit trail of the actions it took in response to these alerts.

The pharmacy stored medicines in the dispensary in their original packaging. And in an orderly manner on the shelves provided. The pharmacy team followed a date checking rota to help manage stock and it recorded details of the date checks it completed. Short-dated medicines were identifiable. The team annotated details of opening dates on bottles of liquid medicines. No out-of-date medicines were found during random checks of dispensary stock. Medical waste bins, clinical waste bins and CD denaturing kits were available to support the team in managing pharmaceutical waste.

The pharmacy held CDs in secure cabinets. Medicine storage inside the cabinets was orderly. Date expired medicines were clearly segregated from stock medicines within one of the cabinets. A pharmacist was observed checking details of a pre-assembled CD against the prescription prior to it being handed out to a person. Pharmacy team members could explain the validity requirements of a CD

prescription. The pharmacy had two medical fridges for storing cold chain medicines. And it recorded its fridge temperatures daily. It generally recorded additional checks or action taken if the temperature recorded was outside the accepted range of two and eight degrees Celsius.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs for providing its services. And equipment is subject to regular monitoring checks to ensure it is safe to use and fit for purpose. Pharmacy team members act with care by using the pharmacy's facilities and 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. 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. Pharmacy team members used NHS smart cards to access people's medication records. The pharmacy stored bags of assembled medicine on shelves to the side of the dispensary. It had a cordless telephone handset. This helped to protect people's confidentiality as pharmacy team members were able to move out of earshot of the public area when discussing confidential information over the telephone.

Equipment to support services such as adrenaline ampoules, needles and syringes were stored securely. Clean, crown stamped measuring cylinders were in place for measuring liquid medicines. And these included separate measures for use with methadone. The pharmacy had clean counting equipment for tablets and capsules. And it had a service contract for managing concerns associated with the MethaMeasure machine. The MethaMeasure computer was replaced the week of inspection. And the supervisor explained how this had provided an upgrade to the latest version of the software. The pharmacy's electrical equipment was subject to scheduled safety checks. Portable appliance testing was next due in October 2020. The surgery completed a weekly health and safety audit. And this included a check of the building's defibrillator, located in the pharmacy's waiting area.

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.