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: 07/09/2022

Pharmacy context

This community pharmacy is within a medical centre on a main road leading into Scunthorpe, North Lincolnshire. It is open extended hours, including late into the evening seven days a week. 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. The pharmacy delivers medicines to people's homes and it provides a 24-hour medicine collection option to people through an automated collection point located outside the premises. It also supplies some medicines in multi-compartment compliance packs, designed to help people to take their medicines.

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	1.1	Good practice	The pharmacy completes regular risk assessments to support it in identifying and managing the risks associated with its services. It uses these risk assessments to inform changes to its procedures and to ensure it keeps its team members informed of these changes.
2. Staff	Standards met	2.5	Good practice	The pharmacy actively engages with team members to promote and respond to their feedback. And it regularly uses their ideas to inform service delivery.
3. Premises	Standards met	3.2	Good practice	The pharmacy's private consultation rooms are fitted out to a notably high standard and are fully accessible to people.
4. Services, including medicines management	Standards met	4.1	Good practice	The pharmacy clearly considers the need of its local community when providing its services. It works well with other healthcare providers by identifying and removing barriers to accessing pharmacy services.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance ✔ Standards met

Summary findings

The pharmacy has robust governance processes that clearly identify and manage risks associated with the services it provides. It undertakes regular risk assessments to support it in identifying and managing the risks associated with its services. And it uses these risk assessments to inform changes to its procedures. The pharmacy keeps people's private information secure. And it mostly keeps the records it must by law. It advertises how people can provide feedback about its services. Pharmacy team members recognise and respond to safeguarding concerns well. They share learning following mistakes made during the dispensing process. And actively refer to guidance and information to support them in working safely within their respective job roles.

Inspector's evidence

The pharmacy had a set of up-to-date standard operating procedures (SOPs). The SOPs covered responsible pharmacist (RP) arrangements, controlled drug (CD) management, and services. The superintendent pharmacist (SI) reviewed the SOPs at regular intervals. And the pharmacy introduced new SOPs as its services changed. For example, it had introduced SOPs to support people collecting their medicine via the automated collection point. Most pharmacy team members had signed training records associated with individual SOPs. And members of the pharmacy team demonstrated competently how they completed tasks associated with their role. For example, a pharmacy technician working in an accuracy checking technician (ACT) role had assurances that a pharmacist had clinically checked a prescription prior to them completing the accuracy check of a medicine. Another team member discussed the tasks that couldn't take place if the RP took absence from the pharmacy.

The pharmacy had robust processes for identifying and managing risks associated with the services it provided. This included completing risk assessments and ensuring team members had completed relevant learning to deliver a service. There were comprehensive SOPs, regularly updated risk assessments and training records associated with the COVID-19 vaccination programme. The pharmacy supported its vaccinators delivering the service by providing quick access to up-to-date information stored in brightly colour-coded folders within consultation rooms. The colour-coded folders referred to the different vaccinations used, information relating to vaccinating pregnant people, and paediatric guidance. This system allowed information to be updated rapidly, and meant that updated guidance was readily available to vaccinators. The pharmacy had recently launched the NHS hypertension case-findings service. In preparation for the service pharmacists had practised fitting the ambulatory blood pressure monitor on trusted volunteers, and had sought feedback following the volunteers wearing the device for 24-hours. The SI explained how this helped support the consultation process and answer questions people may have when accessing the service. The pharmacy had considered infection control risks associated with loaning the ambulatory blood pressure monitor and it had introduced cleaning protocols to support it in managing these risks. The pharmacy was busy preparing for the 2022/2023 flu vaccination season. Preparation for the service in 2021/2022 had included the completion of individual risk assessments for every trip made to care home to administer the vaccine offsite.

Pharmacy team members engaged in consistent near miss and incident reporting following adverse events during the dispensing process. The SI completed monthly patient safety reviews to identify trends in mistakes and the team discussed and agreed actions designed to reduce risk following these

reviews. The pharmacy recorded clear prompts to support its team members during the dispensing process. For example, it recorded safety notes on people's medication records following a dispensing incident, this prompted additional checks when dispensing medicines. And it had implemented tall-man lettering notices to support the correct selection of 'look-alike and sound-alike' (LASA) medicines during the dispensing process. This practice involved writing part of the drug name in upper case letters to highlight differences in names and to help reduce incorrect selection of these medicines. The pharmacy displayed clear guidance associated with the safe and effective running of the pharmacy on notices within the dispensary. These ranged from guidance associated with record keeping to identifying and sharing learning associated with common LASA medicines.

The pharmacy had a complaints procedure. It advertised how people could provide feedback or raise a concern about the pharmacy. And pharmacy team members understood how to respond to concerns and escalate them to the RP, SI or a senior member of the management team if required. The pharmacy displayed a privacy notice and it handled confidential information with care by ensuring it protected people's information from unauthorised access. It had submitted its annual NHS Data Security and Protection (DSP) Toolkit as required. And its team members followed secure procedures when disposing of confidential waste.

The pharmacy had up-to-date indemnity insurance arrangements in place. The RP notice on display contained the correct details of the RP on duty. The pharmacy kept most of its records electronically. The RP record was kept up to date and entries in the CD register conformed to legal requirements and regular stock balance checks were completed. But team members needed to take particular care when dispensing private prescriptions as one private prescription dispensed was not dated, and some records did not reflect the correct details of the prescriber that had written the prescription. Samples of specials records complied with the requirements of the Medicine & Healthcare products Regulatory Agency (MHRA).

The pharmacy had procedures and information relating to safeguarding vulnerable adults and children. This included quick access to contact information for local safeguarding teams. Pharmacy team members had completed some safeguarding training via e-learning and pharmacy professionals had completed level two safeguarding learning. The pharmacy team also had access to advice and support from a GP who held the role of local safeguarding lead. Pharmacy team members understood how to recognise and report safeguarding concerns. And they explained they would discuss any potential safeguarding concerns with the RP and SI in the first instance. The pharmacy was a registered 'safe space' and team members confidently explained what action they would take to safeguard a person attending the pharmacy asking for 'ANI'. The pharmacy worked closely with prescribers to provide vulnerable people with continued access to medicines via daily and weekly dispensing models. It had records in place to monitor the collection of these medicines.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough skilled and knowledgeable people to provide its services safely. It actively monitors and reviews its staffing levels and skill mix. The pharmacy supports the continual learning needs of its team members through offering protected training time. Pharmacy team members support each other well. And they share learning by engaging in regular conversations relating to risk management and safety. They are invited to provide feedback at work. And the pharmacy clearly demonstrates how it considers and uses this feedback to inform improvements to its services.

Inspector's evidence

The pharmacy employed two full-time pharmacists, one of these was the SI who worked two-three days a week in the RP role. A number of regular locum pharmacists also worked at the pharmacy and this had supported consistent cover throughout the pandemic. The RP on duty was a regular locum pharmacist, they were supported by the ACT, the dispensary supervisor (a pre-registration pharmacy technician), two qualified dispensers and a delivery driver. The SI was working in the building and was available if the team required support. The pharmacy also employed another five qualified dispensers, a trainee medicine counter assistant, a pharmacy technician, and another delivery driver. There was a good mix of part-time and full-time roles which provided flexibility within the team to cover both planned and unplanned leave. The SI was in the process of interviewing candidates for a dispenser vacancy, this was due to the planned departure of a team member who was leaving the pharmacy.

Pharmacy team members received protected learning time at work. The pharmacy encouraged its team members to use this time to keep up to date with learning associated with the delivery of its services. The trainee medicine counter assistant was enrolled on accredited training to support their learning. And the pre-registration pharmacy technician discussed feeling supported in their role. A team member discussed how they had been encouraged to attend ‘keeping in touch’ days when on long-term planned leave and explained how this had helped keep them up to date with changes taking place in the pharmacy. The pharmacy had a structured appraisal process but the timescale between appraisals had increased due to the impact of the COVID pandemic.

Pharmacy team members engaged in monthly team meetings and the SI and dispensary supervisor ensured any team members unable to attend a meeting received a handover of the information discussed. The SI shared the outcome of monthly patient safety reviews with team members and improvement actions were clearly recorded within meeting notes. The notes were kept in the form of computerised records which not all team members regularly accessed. This meant it was more difficult for the team to ensure it was working in accordance with the documented actions.

The pharmacy did not set specific targets for the services it provided. And the RP on duty was clear that they could exercise their professional judgement when providing pharmacy services. The pharmacy had a whistle blowing policy. Pharmacy team members had a clear understanding of how to raise and escalate a concern at work. Feedback following a matter which had led to team members being unaware of incoming phone calls to the pharmacy had been acted upon swiftly to ensure a similar incident did not occur. The pharmacy encouraged its team members to contribute their ideas through both informal team discussions and structured staff meetings. The team demonstrated how suggestions

from a patient safety review had led to the reorganisation of the pharmacy's 'top 50' dispensed medicines. The pharmacy held its top 50 lines in a designated area of the dispensary. It had moved away from an alphabetised management system as the team had identified this contributed to errors. It now held these stock medicines in order of dispensing frequency and team members commented on a reduction in near misses involving these medicines following this action.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is secure and maintained to an appropriate standard. It offers a bright, clean, and professional environment for delivering its services. It has an extensive range of private consultation spaces and facilities and these are of a good standard and fully accessible to people.

Inspector's evidence

The pharmacy was professional in appearance and it was secure. It had been refitted during the recent pandemic to create space for the automated collection point. The collection point was not within the registered footprint of the pharmacy and as such people could collect their medicines via the collection point 24-hours a day. The public area of the pharmacy was small and open plan. Signage encouraged people to maintain social distancing. The pharmacy's main consultation room was clearly advertised. The room was brightly lit and air conditioned. There was also a part-screened area to one side of the public space. This provided a semi-private environment allowing people to speak directly to a team member working within the dispensary. Lighting was bright throughout the premises and the pharmacy was air conditioned. All areas of the pharmacy were clean and pharmacy team members had access to appropriate hand washing facilities.

The pharmacy had extended its registered footprint during the pandemic to include additional treatment rooms and a large waiting room which it shared with the medical centre. This allowed it to provide its COVID-19 vaccination service on its registered premises. All consultation rooms used to support the service were fitted to a clinical standard. The dispensary was small for the level of activity taking place. But workload was managed well across the pharmacy's opening hours with risk clearly considered. For example, assembly of multi-compartment compliance packs took place at weekends when demand for other services reduced. Workflow was efficient with dedicated space for labelling, assembling, and checking tasks. Team members had access to kitchen and toilet facilities.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy ensures its services are available to all. It clearly identifies the needs of the local community when considering access to its services, including extending its opening hours. The pharmacy has records and systems in place to make sure people get the right medicine at the right time. It obtains its medicines from reputable sources. And it manages them appropriately to help make sure they are safe to use. Pharmacy team members recognise the benefits of the services they provide. And they complete audit trails effectively to support them in answering any questions related to the pharmacy's services.

Inspector's evidence

The pharmacy was fully accessible through an open plan entrance within the medical centre. Access into the medical centre was through an automatic door, up a ramp with handrails which led from the surgery car park. The pharmacy advertised details of its opening times and services clearly. Its 'healthy living zone' promoted access to the hypertension case-findings service. Pharmacy team members understood the requirement to signpost people on to another healthcare provider or pharmacy. The pharmacy had recently responded to a request to support access to out-of-hours healthcare services in the area by increasing its opening hours on a Sunday. Pharmacy team members had access to practical information to support them in delivering the pharmacy's services over its long opening hours. For example, pictorial guides in the consultation room supported pharmacists providing the NHS hypertension case-findings service. And information relating to recognising red flags, such as signs of sepsis infection was prominently displayed.

The pharmacy's automated collection point was positioned on the front exterior wall of the building, facing the main road. People could access this 24 hours a day to collect their medicines. The pharmacy had considered the risks associated with operating the automated collection point, including the need to obtain consent from people wishing to use the service. Bright stickers identified the bags of assembled medicines assessed as suitable for collection point pick up. The team used barcode and robotic technology to load bags of assembled items into the collection point and people received a text message with a unique pin number on which allowed them to access the collection point. The pharmacy's risk assessment highlighted some medicines which would not be stored in the machine. For example, medicines requiring ongoing monitoring. And it stored these medicines on separate shelving in the dispensary to help prompt additional checks during the dispensing process. The pharmacy didn't store controlled drugs or medicines subject to cold chain storage in the collection point. The SI had created additional SOPs to manage the risks associated with storing some inhalers in the machine once they were removed from the cold chain during the dispensing process. The pharmacy retained the prescriptions associated with the medicines stored in the collection point in a designated filing system. And a team member demonstrated the monitoring checks in place which provided assurance that people had collected their medicines from the collection point. The pharmacy used the text notification service to communicate messages to people. For example, if they needed to attend the pharmacy counter to collect their medicine in person.

The pharmacy protected Pharmacy (P) medicines from self-selection as it displayed them behind the medicine counter. Pharmacy team members used appropriate questioning techniques to assess

requests for these medicines. And they had good awareness of the risks associated with medicines subject to abuse and misuse, with repeat requests referred to a pharmacist. The pharmacy asked people to physically sign to confirm receipt of some higher risk medicines on a separate record stored within the dispensary. This allowed team members to effectively answer any queries relating to the collection of these medicines. Pharmacy team members identified higher risk medicines during the dispensing process. Pharmacists provided verbal counselling when handing out these medicines to people, and a team member demonstrated information recorded on the patient medication record (PMR) system detailing some of the monitoring checks taking place. Pharmacy team members were aware of the requirements of the valproate pregnancy prevention programme (PPP). And the team had the necessary safety information to issue to people in the high-risk group when dispensing valproate. The RP discussed counselling requirements associated with the PPP. The pharmacy completed clinical audits to support it in supplying medicines safely. The RP identified some positive outcomes to services, particularly when supplying people with new medicines. Discussions through the NHS New Medicines Service included providing information about chronic diseases and lifestyle changes people could make to support them in managing their health and wellbeing.

Pharmacy team members signed the 'dispensed by' and 'checked by' boxes on medicine labels when dispensing medicines. It kept records associated with its prescription ordering and medication delivery service to support it in providing the service safely and effectively. The pharmacy used individual profile sheets to support the multi-compartment compliance pack service. These record sheets contained information about a person's medicine regimen. And the team used the sheets to record changes effectively. The pharmacy supplied patient information leaflets alongside compliance packs. Assembled compliance packs contained dispensing audit trails and clear descriptions of the medicines inside. The pharmacy had an automated dispensing machine to assist in supplying its substance misuse services. The pharmacy stored people's prescriptions in individual folders. Prescriptions for people with similar names were put into different coloured folders to help reduce the risk of selecting the wrong record. In addition to the prescription record, individual records clearly identified missed doses. This allowed the team to monitor attendance and take appropriate action when required. For example, if a person had not attended for three consecutive days the prescription was cancelled and the substance misuse team was contacted. People accessing the supervised consumption service had their photograph linked to their record. There was an audit trail in place to identify which pharmacist had entered the prescription data and had completed the clinical check of each prescription. The pharmacy kept a record of the supplies it made associated with the needle exchange service. And all team members providing this service had completed appropriate learning associated with the safe management of sharps.

The pharmacy sourced medicines from licensed wholesalers. It stored these medicines in an orderly manner, within their original packaging, on shelves throughout the dispensary. The pharmacy stored CDs appropriately within secure cabinets. It segregated a number of out-of-date CDs awaiting secure destruction within a cabinet. And it had made an application to the NHS accountable officer's team for the attendance of an authorised witness to support the safe destruction of these medicines. The pharmacy's fridges were clean and a suitable size for the amount of medicines held inside. The pharmacy maintained fridge temperature records. And these showed that medicines were stored within the correct temperature range of two and eight degrees Celsius. Additional monitoring was in place for the fridge holding the COVID-19 vaccinations. The pharmacy team completed regular date checking tasks and it recorded these on a rota. It clearly identified short-dated medicines. A random check of dispensary stock found no out-of-date medicines. The team annotated opening dates on bottles of liquid medicines to ensure these medicines remained fit to supply.

The pharmacy had appropriate medicinal waste bins and CD denaturing kits available. The team received medicine alerts by email. And could demonstrate how it checked and responded to these

alerts. But team members decanted the contents of some 500ml bottles of medicines into larger bottles. The pharmacy managed the risks associated with infection control when doing this. But it did not keep records associated with the batch number and expiry date of the medicine stored within the larger bottles. And the bottles were not clearly labelled with full details of the medicines inside. This meant it could be more difficult for the pharmacy to respond to any concerns related to the medicine if a drug alert was raised.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs for providing its services. It monitors it equipment to ensure it remains in safe working order. And 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 reference resources available. These included the British National Formulary (BNF), BNF for Children and access to up-to-date NICE guidelines. Pharmacy team members accessed the internet to support them in answering queries and signposting people when necessary. The pharmacy's computers were password protected and pharmacy team members used NHS smart cards to access the PMR system. Information on computer monitors was suitably protected from unauthorised view. The pharmacy stored bags of assembled medicines on shelves and in drawers behind the medicine counter. These storage arrangements protected information on bag labels from public view. Pharmacy team members used cordless telephone handsets. These allowed them to move out of earshot of the public area when discussing confidential information over the telephone.

The pharmacy had a good range of equipment to support it in delivering its services and it maintained this equipment appropriately. For example, its blood pressure machines were on the list of monitors validated for use by the British and Irish Hypertension Society. The pharmacy's electrical equipment was subject to portable appliance testing checks and the pharmacy had up-to-date service contracts for its automated collection point and its automated dispensing machine for substance misuse services. Team members completed calibration checks of this machine daily. The pharmacy had a range of clean counting and measuring equipment for liquids, tablets, and capsules.

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.