General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Castlegate Pharmacy, Cockermouth Community Hospital, Isel Road, COCKERMOUTH, Cumbria, CA13 9HT

Pharmacy reference: 1119345

Type of pharmacy: Community

Date of inspection: 22/03/2024

Pharmacy context

This is a community pharmacy in the town of Cockermouth, Cumbria. It is located within a health centre and community hospital. The registered premises are used for both registered activities with the GPhC and for providing dispensing activities to people under the health centre's own dispensing doctor's practice. The pharmacy provides a range of services. These include dispensing NHS prescriptions and selling over-the-counter medicines. The pharmacy provides a home delivery service, a substance misuse service and dispenses some medicines in multi-compartment compliance packs to people who need support in taking their medicine correctly.

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	1.6	Standard not met	The pharmacy does not regularly audit its stock of high-risk medicines and this may make it difficult for the team to resolve any discrepancies.
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 not all met	4.3	Standard not met	The pharmacy holds several expired medicines in its dispensary. This increases the risk of medicines that are unfit for use being supplied to people.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance **Standards not all met**

Summary findings

The pharmacy does not regularly audit its stock of high-risk medicines and this may make it difficult for the team to resolve any discrepancies. The pharmacy has a set of comprehensive written procedures to help the team undertake various processes. And it keeps most of the records it needs to by law. The pharmacy team applies learning following mistakes made during the dispensing process to help prevent similar mistakes happening again. Team members keep people's confidential information secure, and the team is equipped to help safeguard vulnerable adults and children.

Inspector's evidence

The pharmacy had a set of written standard operating procedures (SOPs). These were instructions designed to support the team in safely undertaking various processes. For example, the dispensing of prescriptions and complying with responsible pharmacist (RP) legislation. Team members were required to sign a sheet to confirm they had read and understood the SOPs which were relevant to their role and each team member had signed the sheet. Most of the prescriptions the pharmacy dispensed were issued by the adjacent health centre. The pharmacy had a procedure to separate the activities of the registered pharmacy and the dispensing doctor's practice. Prescriptions were clearly marked to show if they were to be dispensed by the pharmacy, or if they belonged to the dispensing doctor's practice.

If the responsible pharmacist (RP) identified any errors made during the dispensing process, known as near misses, they informed the person responsible for the error and asked them to rectify the mistake. The pharmacy had a near miss log for team members to use to record details of each near miss. The log had sections to record details such as the type of near miss and the reason it might have happened. The team held a short team meeting as soon as a significant near miss was identified. Team members explained they had attended a team meeting on the morning of the inspection following a quantity error. They discussed how they should slow down the dispensing process to avoid similar mistakes being made. The pharmacy used an automated dispensing robot. The robot relied on team members to accurately input medicines into the robot's computer system to prevent selection errors. Team members took care to enter medicine details accurately if they had removed any tablets or capsules from the original pack. And they explained they had focused on ensuring all team members were made aware of an mistakes made when entering medication into the robot. This helped raise awareness and prevent recurrence. The pharmacy had a digital system to record and report dispensing errors that had reached people. Records of such incidents were retained in the pharmacy and reported to the superintendent pharmacist (SI).

The pharmacy had a formal complaints procedure, but it was not advertised for people to see. Team members typically received verbal feedback from people who used the pharmacy. Team members explained how they would always look to resolve complaints themselves but if they were unable to do so, they would refer the complaint to the RP, the SI or the pharmacy's team leader.

The pharmacy had current professional indemnity insurance. The RP notice displayed the name and registration number of the RP on duty. The pharmacy had both a digital and a paper-form RP record. On several occasions, RPs had made entries in only one of the records and so it was not clear which record RPs should use. Within the digital record, RPs had not recorded the time their RP duties had ended on most days. The pharmacy kept records of private prescriptions. It kept CD registers with running

balances and there were separate records of CDs returned to the pharmacy for destruction. Running balances were occasionally audited against physical stock. However, some discrepancies were found when the inspector completed a check of four randomly selected CDs.

Records containing personal identifiable information were kept in areas of the pharmacy that only team members could access. Confidential waste was placed into a separate bag to avoid being mixed with general waste. Then it was periodically destroyed via a specialist contractor. Team members understood the importance of keeping people's private information secure and they had all completed information governance training as part of their employment induction process. Team members offered the use of the pharmacy's consultation room if people wished to discuss their health and there was a risk of the conversation being overheard. The RP had completed training on safeguarding vulnerable adults and children. Other team members had completed internal training and were aware of their responsibilities and when they should escalate any concerns.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy employs several team members who have the appropriate qualifications and skills to provide its services. Team members provide feedback and implement change to the way the pharmacy operates to help improve efficiency. Team members are adequately supported to update their knowledge and skills.

Inspector's evidence

The RP was a locum pharmacist who worked at the pharmacy three days per week. The days the RP didn't work were covered by the SI and other locum pharmacists. During the inspection the RP was supported by a part-time accuracy checking dispenser, five full-time qualified dispensers and a full-time trainee dispenser.

The pharmacy also employed a part-time trainee dispenser, the pharmacy's team leader who was also a qualified dispenser and ten part-time delivery drivers. Team members occasionally worked additional hours to cover each other's absences. They felt they had enough team members to manage the dispensing workload. Team members were observed working well together and helping each other to complete various tasks. They involved the RP when selling higher-risk Pharmacy medicines (P). For example, analgesics that contained codeine. They demonstrated the screening questions they asked people when selling these medicines and explained they would always refer requests for repeat purchases to the RP.

The pharmacy provided team members with access to an online training programme. Each team member had their own login details and could track their own progress through a series of mandatory modules. They also completed additional modules in response to their own identified learning needs. A team member demonstrated that they had recently completed training on safeguarding vulnerable adults and children and supporting people with dementia. The trainee pharmacy assistants were provided with some protected training time to support them in completing their course. But they were not always able to take the time to train during their working hours due to workload pressures. So, they often completed training in their personal time. The pharmacy provided team members with a formal appraisal process. Team members discussed their development and career progression approximately every twelve months with the pharmacy's operations manager.

Team members attended team meetings where they could give feedback on ways the pharmacy could improve. They discussed how they could better manage the workload and talked about improving patient safety. For example, a team member had implemented a system to store medicines collected in instalments in a designated area. This helped other team members easily find these medicines and reduced the time people needed to wait to collect them. Team members were not set any targets to achieve. They explained they were focused on providing an efficient and effective service for the local community.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are kept clean and secure from unauthorised access. The pharmacy has the facilities for people to have private conversations with team members.

Inspector's evidence

The pharmacy was clean, professional in appearance and well maintained. The dispensary was large with several workstations for team members to use to dispense medicines. However, some benches within the dispensary were cluttered and not kept tidy during the inspection. Several boxes were stored on the floor which created a risk of a trip or a fall. The pharmacy had a consultation room for people to have private consultations with team members. It was suitably equipped and soundproofed to prevent conversations being overheard by other people in the retail area.

The pharmacy had a clean sink in the dispensary that was used for the preparation of medicines. There were sinks in both the toilet and staff area which provided hot and cold water and other hand washing facilities. The temperature was comfortable throughout the inspection. Lighting was bright throughout the premises.

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

Summary findings

The pharmacy holds several expired medicines in its dispensary. This increases the risk of it supplying medicines to people that are unsuitable for use. The pharmacy's services are easy for people to access, and it generally manages most of its services safely.

Inspector's evidence

The pharmacy was accessible through the main entrance of the health centre and there was level access into the premises. This allowed easy access into the premises for people who used wheelchairs or had prams. There was a large car park with disabled bays for people visiting the pharmacy to use. And there were seats for people to use while they waited to be served by a team member. The pharmacy had a range of healthcare information leaflets for people to read or take away with them. Team members had knowledge of the Pregnancy Prevention Programme for people in the at-risk group who were prescribed valproate, and of the associated risks. They knew to apply dispensing labels to valproate packs in a way that prevented any written warnings being covered up and ensured they always supplied valproate in original packs.

Team members used dispensing baskets to safely store medicines and prescriptions throughout the dispensing process. This helped manage the risk of medicines becoming mixed-up. Team members signed dispensing labels when they completed the dispensing and final checking processes to maintain an audit trail. The labels were annotated with the name and address of the pharmacy. Team members attached these labels to medicines that had been dispensed under the authority of the dispensing doctors and so, they did not accurately reflect that the medicines were not dispensed by the pharmacy. This issue had not been addressed since being highlighted within the previous inspection of the pharmacy. Team members attached alert stickers to bags containing people's dispensed medicines. They used these as a prompt before they handed out medicines to people. For example, to highlight interactions between medicines or the presence of a fridge line or a CD that needed handing out at the same time. The pharmacy supplied some people with their medicines dispensed into multi-compartment compliance packs. These packs were designed to help people take their medicines at the right times. There were 'master-sheets' which team members used to cross-reference with prescriptions to make sure prescriptions were accurate before the dispensing process began. If they spotted a discrepancy, for example, if a medicine was missing from the prescription, they made enquires with the prescriber. Team members recorded details of authorised changes to people's treatment on their electronic medical record. The packs were supplied with descriptions of the medicines supplied. Team members dispensed the packs in a segregated area of the dispensary. This area was kept organised and tidy to help reduce the risk of mistakes being made.

The pharmacy obtained its medicines from licenced wholesalers. The pharmacy stored P medicines directly behind the pharmacy counter. Prescription only medicines were stored in within the dispensing robot or on shelves in the dispensary. There were several boxes of unorganised, split packs of medicines that had some tablets or capsules removed from the original packs stored around the dispensary. The medicines were due to be booked into the robot in due course, however, team members had not found the time to do so. They followed a process to check the expiry dates of medicines stored within the dispensing robot. They completed this process by scanning the barcodes on the packaging of medicines before they were entered into the robot. The robot's system alerted the team if an expired medicine

was detected. But, the team did not follow the pharmacy's process to check the expiry date of medicines that were not stored in the robot. Twenty expired medicines were found following a check of thirty randomly selected medicines on the pharmacy's shelves. Team members were not seen to be checking the expiry dates of medicines within the dispensing process. These medicines had not been marked as expired, so there was a risk expired medicines could be supplied to people. The pharmacy had two fridges to store medicines that required cold storage. And the team kept keep records of the fridge's minimum and maximum temperature ranges. A sample seen showed the fridges were operating within the correct ranges. The pharmacy had medicine waste bags and bins, sharps bins and CD denaturing kits available to support the safe disposal of medicine waste. The pharmacy received medicine alerts through email. The team actioned alerts and kept a record of the action taken.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the necessary equipment that it needs to provide its services. And it uses its equipment appropriately to help protect people's confidentiality.

Inspector's evidence

Team members had access to electronic and hard copies of the British National Formulary (BNF) and the BNF for Children. The pharmacy used a range of measuring cylinders. There were separate cylinders to be used only for dispensing water. This helped reduce the risk of contamination. The dispensing robot was in working order and it was serviced periodically. There was a blood pressure monitor to support the team in taking blood pressure measurements. There was an otoscope used to undertake ear examinations.

The pharmacy stored dispensed medicines in a way that prevented members of the public seeing people's confidential information. It suitably positioned computer screens to ensure people couldn't see any confidential information. The computers were password protected to prevent any unauthorised access. The pharmacy had cordless phones, so that team members could have conversations with people in private.

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.