General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Willington Pharmacy, Kingfisher Lane, Willington, DERBY, DE65 6QT

Pharmacy reference: 1119949

Type of pharmacy: Community

Date of inspection: 06/10/2022

Pharmacy context

This pharmacy is situated within a medical centre in Willington, which is a village in Derbyshire. People who use the pharmacy are from the local community and a home delivery service is available. The pharmacy dispenses NHS prescriptions, and it provides other NHS funded services such as a COVID-vaccination service. The pharmacy team dispenses medicines into multi-compartment compliance packs for people to help make sure they remember to take them. The pharmacy changed ownership in December 2021.

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 has not adequately identified and managed the risks associated with the COVID vaccination service, and this is impacting on the traditional pharmacy services. And the pharmacy's policies procedures are not always relevant and up to date.
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	4.2	Standard not met	The pharmacy does not always operate efficiently. Prescriptions are dispensed to tight time frames, which could lead to errors.
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 adequately manage the ongoing risks associated with its services, which means it currently has issues in managing the workload. And the pharmacy's policies and procedures are not always relevant and up to date, so team members may not always fully understand their responsibilities. The pharmacy team members are made aware of their mistakes so that they can learn from them, and they make changes to stop the same sort of mistakes from happening again. But some mistakes are not recorded so the team might miss additional opportunities to learn and identify patterns or trends. The pharmacy team keeps people's information safe and team members understand their role in supporting vulnerable people.

Inspector's evidence

The pharmacy was part of a small independent chain of pharmacies. A range of corporate standard operating procedures (SOPs) were available which covered the activities of the pharmacy and the services provided. Roles and responsibilities were highlighted within the SOPs. It was unclear when the SOPs had been produced or last reviewed. One of the documents stated that it should have been reviewed in 2017, but there was nothing indicating that this review had taken place. The pharmacist manager explained that he had asked the pharmacy team to read the SOPs when the pharmacy ownership changed, but the team members had not invested much time on this as the pharmacy was expecting a new set of electronic SOPs to be released by head office in the near future. Some of the pharmacy team members said that they had briefly read some of the SOPs, but time pressures meant that it had not been a priority.

Many of the pharmacy's processes and records were electronic, which meant that they were easily accessible and there were alerts within the computer system to remind the pharmacy team to do certain tasks. Near miss records were held on this system and a 'dashboard' summarised the number of near misses recorded. There were Quick Response (QR) codes displayed in the dispensary so that the dispensers could scan the QR code using their mobile phone and enter the details of the near miss. There were several months where no near misses had been recorded, and the team explained that they had been 'too busy' to record them. Three dispensers were usually involved in the dispensing process; one labelled the prescription, one collected the medicines, and one assembled the prescription. Near misses that were identified by the dispensers, such as labelling errors or the wrong medicine picked, were not recorded by the team as a near missed as they had not reached the pharmacist for checking, so this information was not used to promote learning. The pharmacy team gave some examples of different types of mistakes and demonstrated some examples of how the dispensary layout had been adapted to try and avoid the same mistake happening again. Dispensing errors were recorded, reviewed and reported to the company's clinical governance lead using the electronic system. The governance lead reviewed the error and contacted the pharmacist manager if anything else was required.

The pharmacy had recently started to offer a COVID-vaccination service and a clinic was running during the inspection. The vaccinator was a pharmacist and said that he was administering the vaccination

using the National Protocol and that the pharmacist manager was the clinical lead. It was the vaccinators first time working at this pharmacy, although he had administered vaccinations when working at other pharmacies. There were folders containing NHS policies, SOPs, the National Protocol, Patient Group Directions (PGDs) and various templates for audits. Only two of the documents in the folders had been tailored to the pharmacy; these were the PGD that named the pharmacist manager, and an infection control checklist that had been completed in September 2022. The pharmacist manager explained that the service had been set up by the superintendent (SI) and he appeared unclear of his responsibilities as clinical lead. There was no evidence of risk assessments being completed, some documents in the folder were out of date, and there did not appear to be any competency checks for the visiting vaccinators.

Members of the pharmacy team were knowledgeable about their roles and discussed these during the inspection. A trainee medicines counter assistant correctly answered hypothetical questions related to high-risk medicine sales.

People could give feedback to the pharmacy team in several different ways; verbal, written and online. The pharmacy team tried to resolve issues that were within their control and would involve the SI or RP if they could not reach a solution. There had been feedback about the pharmacy on social media and the team were aware of this.

The pharmacy had up-to-date professional indemnity insurance. The Responsible Pharmacist (RP) notice was clearly displayed. The RP log was electronic and met requirements. Electronic controlled drug (CD) registers were in order and random balance checks matched the balances recorded in the register. A CD balance audit was, on average, carried out monthly. Private prescription records were seen to comply with requirements. Specials records were maintained with an audit trail from source to supply. An audit trail for deliveries was maintained.

Confidential waste was stored separately from general waste and destroyed securely. The pharmacy team had their own NHS Smartcards and confirmed that their passcodes were not shared. The pharmacists had completed level 2 training on safeguarding. The pharmacy team members understood what safeguarding meant and a dispenser gave examples of hypothetical safeguarding concerns and how she would report them.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy team members receive the right training for their roles. The team are working under pressure to meet the current workload. The staffing level required for the pharmacy's workload is not always well planned which can lead to a backlog of work, and this creates a difficult working environment for the team. The team members work well together, and they can raise concerns and make suggestions.

Inspector's evidence

The pharmacy team comprised of the pharmacist manager, four dispensing assistants, a trainee dispensing assistant, an apprentice, a medicine counter assistant, four trainee medicine counter assistants and a delivery driver. Since the pharmacist manager had started working at the pharmacy, he had reviewed the skills mix of the team. He had enrolled members of the team onto training courses and had recruited new team members to replace people that had resigned. For example, two of the dispensing assistants had been enrolled onto a level three course, an apprentice had been recruited, and three people had been enrolled onto a medicine counter assistant course. This meant that all of the team members had either completed or were working towards the appropriate qualification for the role they were undertaking.

Annual leave was booked in advance, and it was clear when people were off. The pharmacy team organised cover between themselves. A part-time trainee medicines counter assistant was working additional hours so that there was a staff member planned to work on the medicines counter to manage the increased number of people that were coming into the pharmacy due to the COVID vaccination service. The team were finding the workload challenging and were behind on some of the activities. For example, prescriptions that had been received electronically from the surgery were not always ready when people came into the pharmacy to collect them, and this took the team away from their other tasks whilst they looked through the baskets of part-dispensed prescriptions. The increased number of people coming into the pharmacy, combined with the increased time it took to find prescriptions required dispensers to go onto the medicines counter to try and reduce the queue, and this took them away from dispensary tasks. The pharmacist manager said that recruitment was difficult as very few people had applied for the vacancies that had been advertised previously.

The pharmacy team members knew their role within the dispensary and different tasks were allocated to different team members to help manage the workload. The team worked well together during the inspection and were observed helping each other and moving from their main duties to help with more urgent tasks when required. The team had a WhatsApp group where they shared information, they said that this was useful as many of them worked part time and this meant that everyone got the same information. The pharmacist managers within the pharmacy group also had a WhatsApp group where they shared information. Members of the team discussed any pharmacy issues with their colleagues as they arose, and they held meetings in the dispensary. The pharmacy staff said that they could raise any concerns or suggestions with the pharmacist manager, SI, or they would contact the GPhC. The pharmacist manager was observed making himself available to discuss queries with people and giving

advice when he handed out prescriptions. Some targets were set for professional services and the pharmacist manager felt able to use his professional judgement when offering services.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy provides a safe, secure and professional environment for people to receive healthcare. The pharmacy team uses a consultation room for some services, such as vaccinations.

Inspector's evidence

The premises were smart in appearance and appeared to be well maintained. Any maintenance issues were reported to head office. The dispensary was an adequate size for the services provided; an efficient workflow was seen to be in place. Dispensing and checking activities took place on separate areas of the worktops. Prepared medicines were held securely within the pharmacy premises and pharmacy medicines were stored behind the medicines counter.

There was a consultation room which was being used throughout the inspection for administering COVID vaccinations. The consultation room was professional in appearance and there was a computer terminal so that data could be imputed into the NHS system during the consultation. The door to the consultation room was open throughout the inspection, which would allow air to circulate. However, it meant that people's privacy was not always protected, and their personal information could potentially be overheard by other people waiting for their vaccination. There was a second consultation room which was being used to prepare compliance pack trays. This room contained medicines and confidential information. The door to this room was propped open at the start of the inspection but was closed and locked to prevent unauthorised access when this was pointed out to the team.

The pharmacy was clean and tidy with no slip or trip hazards evident. It was cleaned by the team, and the consultation room and seating area was cleaned at the end of the day when a vaccination clinic had finished operating. The sinks in the dispensary and staff areas had hot and cold running water, hand towels and hand soap available. The pharmacy had air conditioning and the temperature felt comfortable during the inspection. The lighting was adequate for the services provided.

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

Summary findings

The pharmacy's processes are not as efficient as they need to be to deliver the current workload, which means there is often a backlog of work. However, the pharmacy generally supplies medicines safely and people receive appropriate advice about their medicines when collecting their prescriptions. It gets its medicines from licensed suppliers and the team makes checks to make sure they are safe to use.

Inspector's evidence

The pharmacy had step free access from a large car park and a home delivery service was offered to people who could not access the pharmacy. The pharmacy staff referred people to other local services, such as smoking cessation services, when necessary. The pharmacy staff used local knowledge and the internet to support signposting. The pharmacist manager had regular meetings with people from the surgery and explained that he had been trying to improve the working relationship between the surgery and the pharmacy.

Items were dispensed into baskets to ensure prescriptions were not mixed up together. Different coloured baskets were used to prioritise certain prescriptions. Staff signed the dispensed and checked boxes on medicine labels, so there was a dispensing audit trail for prescriptions. Notes and stickers were attached to medication when there was additional counselling required or extra items to be added to the bag. The team were aware of the risks associated with the use of valproate during pregnancy, and the need for additional counselling. Patient cards and counselling materials were available.

Multi-compartment compliance packs were supplied to people in the community. Prescriptions were requested from the surgeries to allow for any missing items to be queried with the surgery ahead of the intended date of collection or delivery. A sample of dispensed compliance pack prescriptions were labelled with descriptions of medication and patient information leaflets were sent with each supply. There was a process in place for managing mid-cycle change requests. The dispensing assistant responsible for the compliance pack service had recently left the pharmacy and had written a comprehensive guide for the team to ensure that there was continuity for patients. The pharmacist manager and the new dispenser responsible for dispensing the packs had reviewed the notes and had contacted some patients as they felt this was a good opportunity to assess whether compliance packs were the most suitable device for people.

The pharmacist manager and dispensing assistant had identified that it was inappropriate to supply medication in a compliance pack by cutting the blister pack and placing this inside the pack. There was a risk that people could attempt to swallow the medication without removing the packaging which could cause harm to the person's gastrointestinal system. They had contacted the patients that had medication dispensed like this and arranged an alternative solution.

The pharmacy used a separate vaccinator to carry out the COVID-19 vaccination service so that the responsible pharmacist could focus on the traditional pharmacy services. The pharmacy listed the

available clinic times on the NHS website, so that people could book an appointment and the pharmacy knew how many people they were expecting for each vaccination clinic. The pharmacy also offered walk-in appointments if they had sufficient stock. Vaccines were stored in the pharmacy fridge and the stock was audited and reported to NHS at regular intervals. The anaphylaxis kit was stored in the dispensary and the vaccinator said that there was room to lay someone down on the floor in the consultation room and shout for help from the rest of the team in the unlikely event of a medical emergency. The pharmacy team booked people in when they arrived and asked some initial screening questions at the medicines counter. There was one member of the team assigned to the medicines counter and there were often long queues as the team member was also handing out prescriptions.

Local surgeries had implemented a system where people ordered their repeat prescriptions from a central ordering point and the pharmacy could not order on behalf of the person. The change in system was causing issues for the pharmacy team as it made it difficult to plan their staffing and workload as they did not know how many repeat prescriptions they were expecting each day. People were returning to the pharmacy to collect their prescriptions as soon as they had received notification from the system that it had been sent to the pharmacy, however, this did not give the pharmacy team enough time to dispense the prescription and obtain any additional stock from wholesalers. Sorting through the prescriptions to locate a specific one was causing additional pressures to the team. Whilst the team members were working hard, the circumstances meant the process was inefficient.

The dispensary and shop areas were date checked regularly and short dated stock was listed and marked so that it could be removed from the shelf prior to its expiry date. The out-of-date list had not been checked for the current month and there were various out of date medicines still on the shelves, but these medicines were clearly marked so the team members knew they should not be dispensed. Split liquid medicines with limited stability once they were opened were marked with a date of opening. Patient returned medicines were stored separately from stock medicines in designated bins. Drug recalls were received electronically and marked when they were actioned. The CD cabinet were secure and a suitable size for the amount of stock held. Medicines were stored in an organised manner inside. Fridge temperature records were maintained, and records showed that the pharmacy fridge was working within the required temperature range of 2°C and 8°Celsius.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide its services safely. And the team uses it in a way that keeps people's information safe.

Inspector's evidence

The pharmacy had a range of up-to-date reference sources, including the BNF and the children's BNF. Internet access was available. Patient records were stored electronically and there were enough terminals for the workload currently undertaken. A range of clean, crown stamped measures were available. Separate measures were used for the preparation of methadone. Counting triangles were available. Computer screens were not visible to the public as members of the public could not access the dispensary. Cordless telephones were in use and staff were observed taking phone calls in the back part of the dispensary to prevent people using the pharmacy from overhearing. The pharmacy had a dispensing robot which took up space in the dispensary. The new owners had made the decision not to use the robot, so it was switched off and it did not contain any stock.

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.