General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Well, North Carlisle Medical Centre, Eden Street, CARLISLE, CA3 9JZ

Pharmacy reference: 1124210

Type of pharmacy: Community

Date of inspection: 12/01/2024

Pharmacy context

This is a community pharmacy next to a large medical centre in Carlisle, Cumbria. Its main services include dispensing NHS and private prescriptions and selling over-the-counter medicines. The pharmacy provides services such as the NHS hypertension case-finding service and a seasonal 'flu vaccinations. And it delivers some medicines to people's homes.

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	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 provides it team members with a comprehensive set of written procedures to support them in safely managing its services. It keeps people's sensitive information secure, and its team members are suitably equipped to safeguard vulnerable adults and children. The pharmacy has a process for team members to record and analyse mistakes made during the dispensing process.

Inspector's evidence

The pharmacy provided its team members with a comprehensive set of digital standard operating procedures (SOPs). The SOPs provided the team members with information and instructions on how to complete various tasks. For example, managing controlled drugs (CDs) and dispensing medicines in multi-compartment compliance packs. Each SOP had been created by the pharmacy's head office team and were scheduled to be reviewed every two years. The review process ensured the SOPs were kept up to date and accurately reflected the pharmacy's way of working. Team members present during the inspection confirmed they had read and understood the SOPs that were relevant to their roles. They had completed a short quiz to assess their understanding of each SOP. The pharmacy's area manager had oversight of each team member's progress with completion of the SOPs. The responsible pharmacist (RP) confirmed that team members who were not present during the inspection had also read and understood each SOP that was relevant to their role.

Team members used an electronic system to record details of mistakes made during the dispensing process which had been identified by the RP before supply to a person. These mistakes were known as 'near misses'. Records were made by the dispenser who had made the near miss. Team members explained this helped them take responsibility for their mistakes and supported their learning. They recorded details such as the time, date, and type of near miss. The system produced reports of the near misses each month to identify trends and patterns. Team members described some common near misses involving medicines that were produced in several different strengths but had similar looking packaging. For example, a team member described how they had occasionally dispensed amlodipine 5mg instead of 10mg. To reduce the risk of further selection errors, the team ensured the two strengths were kept apart from each other on dispensary shelves. The pharmacy used the electronic system to report and record details of dispensing incidents, which were errors identified after people had received their medicines. The RP was responsible for completing the report forms. Team members held a meeting following a dispensing incident to help raise awareness and discuss what they could do to prevent a similar incident happening again.

The pharmacy had a procedure to support people in raising concerns about the pharmacy. It was outlined within a leaflet stored in the pharmacy's consultation room. Any concerns or complaints were usually raised verbally with a team member. If the team member could not resolve the complaint, it was escalated to the pharmacy's superintendent pharmacist (SI) team.

The pharmacy had current professional indemnity insurance. It was displaying an RP notice which showed the full name and General Pharmaceutical Council (GPhC) registration number of the RP. A sample of the RP record inspected was completed correctly. The pharmacy kept digital records of supplies against private prescriptions. A sample seen were held in line with legal requirements. The pharmacy maintained complete CD registers. And of the sample checked, the team kept them in line

with legal requirements. The team completed balance checks of the CDs against the physical quantity in stock each week. The inspector checked the balance of two randomly selected CDs which was found to be correct. The pharmacy kept complete records of CDs returned to the pharmacy for destruction.

The team held records containing personal identifiable information in areas of the pharmacy that only team members could access. The team placed confidential waste into a separate container to avoid a mix up with general waste. The waste was periodically destroyed via a third-party contractor. Team members understood the importance of securing people's private information. They described how they offered people the use of the pharmacy's consultation room if people felt uncomfortable discussing their health in the retail area. Each team member had completed formal training on the safeguarding of vulnerable adults and children. The RP had completed safeguarding training via the Centre for Pharmacy Postgraduate Education (CPPE). The RP was aware of a written procedure held in the pharmacy that the team could use to support them in raising a safeguarding concern. But the team was unable to locate it during the inspection. Team members accurately described hypothetical safeguarding situations that they would feel the need to report.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has a skilled and experienced team to help manage the workload. Team members are supported in their development and have access to a comprehensive training programme to support them in keeping their knowledge and skills up to date. Team members feel comfortable to provide feedback to improve the pharmacy's services.

Inspector's evidence

The RP was the pharmacy's regular pharmacist. They worked full time with locum pharmacist support on days they didn't work. During the inspection the RP was supported by two part-time qualified pharmacy assistants, a full-time trainee pharmacy assistant and a qualified relief pharmacy assistant. The pharmacy also employed three delivery driver who worked part-time and another qualified pharmacy assistant who was also the pharmacy's manager. Throughout the inspection, team members were observed working efficiently. Team members were supporting each other in completing various tasks. They could cover each other's absences by working additional hours if required. The relief pharmacy assistant worked on an ad-hoc basis and was asked to support the pharmacy during busier periods of business. The team explained how this helped them plan the workload in advance and helped to provide a more efficient service to people.

The pharmacy had a formal training programme for its team members. This included a series of online healthcare related training modules for the team to complete. Most of the modules were mandatory for team members to complete, and they were accompanied with short quizzes designed to test team members' understanding of the subject. The trainee pharmacy assistant was occasionally allocated protected training time to help them work through their training programme, but they completed most of the training in their personal time. Team members voluntarily completed a module if they felt they needed additional support with their learning in that area. Team members engaged in an appraisal process which included completion of a pre-appraisal form to record their development goals. Team members explained how they would raise any concerns with the pharmacy's manager and felt comfortable providing feedback to help improve the pharmacy's services.

The team was set some targets to achieve by the pharmacy's owners. These included the number of prescriptions dispensed and retail sales. Team members felt the targets were generally achievable and were not under any significant pressure to achieve them. Team members had access to the pharmacy's whistleblowing policy to support them in raise any concerns anonymously.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are well maintained and are suitable for the services the pharmacy provides. The pharmacy has appropriate facilities for people to have private conversations with team members.

Inspector's evidence

The premises was well maintained and kept clean and hygienic. The dispensary was spacious and kept organised throughout the inspection. The benches in the dispensary were well organised with baskets containing prescriptions and medicines awaiting a final check all stored in an orderly manner. There was a separate bench used by the RP to complete final checks of medicines. This helped reduce the risk of mistakes being made within the dispensing process. The pharmacy had sufficient space to store its medicines. Floor spaces were kept clear from obstruction which helped reduce the risk of a trip or fall. There was a consultation room available for people to use to have confidential conversations with team members about their health.

The pharmacy had separate sinks available for hand washing and for the preparation of medicines. There was a toilet, with a sink which provided hot and cold running water and other facilities for hand washing. Team members controlled unauthorised access to restricted areas of the pharmacy. Lighting was bright throughout the premises.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides a range of services to support people in managing their health. The services are well managed by the team, and the processes team members follow help people to take their medicines correctly. The team stores medicines in the dispensary appropriately and undertakes regular checks to ensure they are fit for purpose.

Inspector's evidence

The pharmacy had level access from the health centre car park to the main, power-assisted entrance door which helped people using wheelchairs access the pharmacy. The car park had several disabled car parking spaces for people to use. The pharmacy advertised its opening hours and its services on the main entrance door. It had the facility to provide large-print labels to people with a visual impairment. Team members described how they supported people with a hearing impairment to access the pharmacy's services. This included providing written messages to people and speaking slowly. Team members were aware of the Pregnancy Prevention Programme (PPP) for people in the at-risk group who were prescribed valproate, and of the associated risks. They were aware of recently issued legislation to ensure pharmacies supplied of valproate in the original manufacturers packaging. The pharmacy provided an NHS hypertension case-finding service. Team member demonstrated examples of where they had identified people who had hypertension and explained how they had provided suitable advice to people to help them manage their blood pressure. This included giving dietary advice or referring them to their GP where appropriate. The pharmacy was providing a seasonal 'flu vaccination service. Team members ensured the reminded people who were eligible for a 'flu vaccination the importance of being vaccinated.

Team members used various stickers to attach to bags containing people's dispensed medicines. They used these as an alert before they handed out medicines to people. For example, to prompt the team to offer a person a blood pressure check as part of the hypertension case-finding service. Team members signed the dispensing labels to keep an audit trail of which team member had dispensed and completed a final check of the medicines. They used dispensing baskets to hold prescriptions and medicines together which reduced the risk of them being mixed up. The pharmacy had owing slips to give to people when the pharmacy could not supply the full quantity prescribed. It sent a text message to people to inform them their prescriptions had been dispensed and were ready to be collected. The pharmacy offered an optional delivery service and kept records of completed deliveries. The pharmacy sent several prescriptions to be dispensed at the pharmacy's offsite hub pharmacy. This was so help reduce the team's dispensing workload. Team members input data from each prescription onto the pharmacy's computer system. The data was accuracy and clinically checked by the RP before being sent to the hub for dispensing. The pharmacy dispensed antibiotics and other more urgent medicines on prescriptions locally. Team members were also able retrieve any prescriptions to be dispensed locally on request. For example, if a person could not wait for their medicines to be delivered to the pharmacy from the hub and needed them urgently. Team members annotated medicines on prescriptions with 'H' if they were dispensed at the hub and 'L' if they were dispensed locally. This helped reduce the risk of any medicines being dispensed twice.

The pharmacy stored several pharmacy-only (P) medicines in clear boxes around the retail area. The boxes had clear instructions on them informing people to ask for assistance from team members if they

wished to purchase one of the medicines stored inside. Team members often intervened when they noticed people opening the boxes without assistance. However, they explained the location of the boxes meant they were not always able to intervene each time. And so, the pharmacy relied on team members noticing that these medicines required the appropriate checks before making a sale. Team members were aware of the screening questions to ask people before selling a P medicine. Team members checked the expiry date of the pharmacy's medicines every three months and kept complete records of the process. They were up to date with the process. No out-of-date medicines were found following a check of approximately 20 randomly selected medicines. Team members highlighted expiring medicines using alert stickers. The pharmacy used three clinical-grade fridges for storing medicines that required cold storage. Medicines stored inside the fridge were kept tidy. Each fridge was operating within the correct temperature ranges. Team members checked and recorded the temperature of the fridge each day to make sure it was operating correctly. They reported any instances of the fridge operating outside of the correct ranges. Drug alerts and recalls were received electronically by the team. They actioned them as soon as possible and kept a record of the action taken.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the appropriately maintained 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 up-to-date reference sources including copies of the British National Formulary (BNF) and BNF for children. The pharmacy used a range of CE marked measuring cylinders. There was a suitable, electronic blood pressure monitor to support the team in providing the NHS hypertension case-finding service. The monitor was scheduled to be replaced each year. There were suitable adrenaline pens, sharps bins, plasters, and swabs to support the team in delivering 'flu vaccinations.

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.