General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Wyvern Pharmacy, 81 Abbey Street, Accrington, Lancashire, BB5 1EH

Pharmacy reference: 9010380

Type of pharmacy: Internet / distance selling

Date of inspection: 28/06/2024

Pharmacy context

This is a distance-selling community pharmacy situated on a high street in the town of Accrington, Lancashire. Its website is www.wyvernphamacy.co.uk. Its main services include dispensing NHS and private prescriptions. It also provides an onsite, private ear syringing service, a private flu vaccination service and the NHS Pharmacy First service. The pharmacy offers a prescribing service for various minor ailments via a pharmacist independent prescriber. The pharmacy supplies some people with their medicines dispensed into multi-compartment compliance packs, designed to help people remember to take their medicines. All medicines dispensed by the pharmacy are delivered to people.

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's team members have access to a set of written procedures to help them manage most of the services provided to people. They are suitably trained to support the safeguarding of vulnerable adults and children. The pharmacy keeps people's sensitive information secure. Team members recognise the importance of recording and reflecting on any mistakes made during the dispensing process. They look to identify trends or patterns in the records and implement changes to the way they work to manage risks.

Inspector's evidence

The pharmacy had a comprehensive set of digital standard operating procedures (SOPs) for its team to use. The SOPs provided the team members with information to help them complete various tasks. For example, managing controlled drugs (CDs). The SOPs were updated every two years to ensure they accurately reflected the pharmacy's services. Team members read the SOPs when they were introduced and updated, however there were no records maintained to confirm this. The pharmacy offered a prescribing service for various minor ailments such as sore throats and chest infections. Prescriptions were issued by one of the pharmacy's regular pharmacists who was a qualified independent prescriber. The pharmacy did not have any SOPs or documented risk assessments for the service. But it had implemented measures to manage some of the risks associated with the service. The prescriber carried out a face-to-face assessment with people and completed a screening questionnaire before any medicines were prescribed. They documented the persons medication history, alcohol intake and family and social histories. This was recorded on the person's electronic medical record and on the reverse of any issued prescriptions. This ensured the pharmacy had documented records should a person require future treatment.

The pharmacy team used both a digital and a paper system to record details of mistakes made during the dispensing process which were identified before a medicine was supplied to a person. These mistakes were known as near misses. The pharmacy had recently introduced the digital system which each team member knew how to access and use. The responsible pharmacist (RP) explained they preferred to use a paper near miss log as the team was more likely to remember to record each near miss. Records on the paper log were vague in comparison with those made on the digital system as they lacked details of any contributory factors. And so, the team may have missed the opportunity to identify trends or patterns. Each month, team members completed a basic analysis of the near miss records and discussed significant near misses with each other. They discussed ways they could change the way the pharmacy operated to reduce the risk of specific near misses being repeated. For example, separating medicines that had similar names or packaging. The team used the same system to report and record dispensing incidents that had reached people. The team followed a process to investigate the incident to help establish any contributing factors that may have caused the error and implement an action plan to reduce the risk of a similar mistake recurring. The pharmacy did not advertise its feedback and complaints procedure clearly to people who used the pharmacy. Team members explained that feedback, complaints, and suggestions were generally received verbally via telephone. The pharmacy's contact details were clearly advertised on its website.

The pharmacy had current professional indemnity insurance. It was displaying two RP notices and so the RP on duty was not clearly identifiable. This was discussed with the RP. A sample of the RP record

inspected was mostly completed correctly, however on some occasions, the RP had not recorded the time their RP duties had ended. The pharmacy kept records of supplies against private prescriptions. However, the date the prescription was issued and the date of supply were not always made clear. The pharmacy retained complete, electronic, CD registers. And of the sample checked, the team kept them in line with legal requirements. The team checked that the physical quantities of CDs matched the balance recorded in the register each week. The inspector checked the balance of a randomly selected CD which was found to be correct. The pharmacy kept complete records of CDs returned to the pharmacy for destruction.

Team members completed mandatory learning on the protection of people's confidentiality and data protection. 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. The RP had completed mandatory learning on the safeguarding of vulnerable adults and children. The pharmacy had a formal procedure to support team members in reporting any concerns identified. They described hypothetical scenarios that they would report. The contact details of the local safeguarding teams were readily available to the team.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy employs a team with the appropriate skills to manage the workload safely and effectively. It adequately supports team members to update their knowledge and skills regularly. Team members are encouraged to provide feedback on the pharmacy's processes to help improve service delivery.

Inspector's evidence

The RP was the pharmacy's superintendent pharmacist (SI) and worked at the pharmacy for three days a week. The pharmacy's other pharmacist worked on the days the SI was absent. This pharmacist was a qualified independent prescriber. During the inspection the RP was supported by a full-time, qualified pharmacy dispenser and a full-time trainee pharmacy dispenser. The pharmacy also employed another full-time, qualified pharmacy dispenser and two part-time delivery drivers. These team members were not present during the inspection. 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, however team members explained this was not common as they felt they had enough team members to efficiently manage the workload. The pharmacy had recently made changes to its staffing rotas by ensuring that more team members were working on Fridays as this was the pharmacy's busiest day.

The trainee pharmacy dispenser was enrolled onto an GPhC accredited course and was progressing well. On discussion, they described how they felt well supported by the pharmacist and colleagues to help them work through the course. And they felt comfortable asking for support when met with aspects of the course they found challenging. The pharmacy did not provide qualified team members with a structured training programme to support them in updating their learning and development needs. However, they took the time during their working hours to read training material that had been provided to the pharmacy by third-party contractors on an ad-hoc basis. The qualified dispenser described how they had taken some time to gain a better understanding of the conditions some specific medicines were commonly prescribed for.

The pharmacy had a whistleblowing policy to help support team members raise a concern anonymously. Team members attended regular meetings with the RP to discuss workload and discuss any feedback they wished to share. For example, they team had recently discussed introducing the use of coloured baskets to store prescriptions and medicines. This helped the team separate the workload in an efficient manner. The RP and the pharmacy's second pharmacist had weekly discussions to discuss the pharmacy's workload. The team was not set any targets to achieve by the pharmacy's owners.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises is well maintained and suitable for the services provided. The pharmacy has the facilities for people to have private consultations with team members.

Inspector's evidence

The pharmacy was modern, professional in appearance, well maintained and kept clean and hygienic. There was a ground floor reception area where people could hand in prescriptions or register one of the face-to-face services offered by the pharmacy. There was a waiting area where people could comfortably wait for their appointment. To the rear of the reception area was a large, soundproofed, consultation room. The room was kept tidy, well organised, and professional in appearance. The room was also used as an office area and all paperwork and files were stored in locked cabinets. The dispensary was located on the first floor of the premises. It was of a suitable size and was kept well organised throughout the inspection with baskets containing prescriptions and medicines awaiting a final check stored in an orderly manner. There was a separate area used by the RP to complete the final check of prescriptions. This helped reduce the risk of mistakes being made within the dispensing process. There was ample space to store the pharmacy's medicines. The dispensary floor was kept clear of obstruction.

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. Throughout the inspection, the temperature was comfortable. Lighting was bright throughout the premises.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy offers a range of services that are made easily accessible to people. The pharmacy team ensures these services are managed safely. The pharmacy stores and secures its medicines appropriately and team members completed regular checks to ensure the medicines are fit for purpose before being supplied to people.

Inspector's evidence

Although a distance-selling pharmacy, people accessed the pharmacy for some services that required a face-to-face consultation. All prescriptions dispensed by the pharmacy were delivered to people. The pharmacist prescriber offered a prescribing service for several minor ailments such as sore throats and urinary tract infections. And they previously offered a weight loss service. The pharmacist prescribed medicines following a face-to-face consultation with the person. The pharmacist had significantly reduced the volume of prescriptions issued for minor ailments since the introduction of the NHS Pharmacy First service through which many of the conditions could now be treated. The pharmacy had stopped providing the weight loss service several months before the inspection. The pharmacist explained this was due to a lack of medicine availability and to avoid prescribing weight loss medicines for people when treatment may be stopped if the medicine became unavailable at short notice. The pharmacy did not advertise the prescribing service to people. 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.

Throughout the dispensing process team members used baskets to help keep people's prescriptions and medicines together and reduce the risk of them being mixed up which could lead to errors being made. The baskets were of differing colours to help segregate the workload. Team members initialled the dispensing labels to help maintain an audit trail of which team member had dispensed the medicines and who had completed the final check. The pharmacy had owing slips to give to people when the pharmacy could not supply the full quantity prescribed. The pharmacy offered a delivery service and kept records of completed deliveries. Almost all of the deliveries were made to people living locally. Deliveries were completed by an employed deliver driver. Team members obtained advanced consent before they posted any medicines if people were not available to take receipt of them. Where posting a medicine was not suitable, the pharmacy's deliver driver posted a note and sent a text message to people informing people that their medicines had been returned to the pharmacy. And they were required to contact the pharmacy to arrange an alternative delivery date.

The pharmacy supplied several people living in their own homes with medicines dispensed in multi-compartment compliance packs. These packs were designed to help people take their medicines at the correct times. Dispensed packs were well organised on shelves. Team members had implemented several steps to help them manage the process safely and effectively. These steps included spreading the workload evenly over four, colour-coded weeks. Prescriptions and 'master sheets' for each person that received a pack were stored in individual, clear wallets. The master sheets had a list of each medicine that was to be dispensed into the packs and times of administration. Team members annotated the master sheets with details of any changes a prescriber may have authorised. For example, if a medicines strength was increased or decreased. The packs were supplied with patient information leaflets, and some were annotated with descriptions of the medicines inside to help people

visually identify them.

Team member checked the expiry date of the pharmacy's medicines every three months and kept records of the process. No out-of-date medicine were found following a check of approximately 30 randomly selected medicines. Team members highlighted medicines with short expiry dates using alert stickers. The team marked bulk, liquid medicines with details of their opening dates to ensure they remained fit to supply. One liquid medicine was identified that had not marked. This medicine was brought to the attention of a team member who removed it from the dispensary. The pharmacy used a fridge to store medicines that required cold storage. The operating temperature ranges of the fridge was checked and recorded by a team member each day to ensure they were within the accepted range of 2 to 8 degrees Celsius. A sample of the record showed both fridges were operating within the accepted temperature range. Medicines stored in the fridges and CD cabinets were kept well organised. The pharmacy received drug alerts via email. Team members actioned the alerts as soon as possible and kept a record of the action taken to maintain an audit trail.

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

The pharmacy used a range of CE marked measuring cylinders for preparing liquid medicines. There was suitable equipment to support the team to manage the NHS Pharmacy First service and to measure people's blood pressure. This included an otoscope and several digital blood pressure monitors. The pharmacy stored dispensed medicines in the dispensary which prevented members of the public seeing people's confidential information. It suitably positioned the computer screen in the consultation room to ensure people could not see any confidential information. The computers were password protected to prevent any unauthorised access.

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.