General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Well, Medical Centre, Belvoir Health Group, Candleby Lane, Cotgrave, Nottingham, Nottinghamshire, NG12 3JG

Pharmacy reference: 9011103

Type of pharmacy: Community

Date of inspection: 28/08/2019

Pharmacy context

The community pharmacy is part of a community multiservice centre in a building alongside other services for local people. It is in a semirural village in Nottinghamshire. The pharmacy sells over-the-counter medicines and dispenses NHS and private prescriptions. It offers advice on the management of minor illnesses and long-term conditions. It supplies medicines in multi-compartmental compliance packs, designed to help people remember to take their medicines. And it delivers 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	1.3	Good practice	Pharmacy team members have clearly defined roles. And they effectively use audit tools and information within the pharmacy's procedures to ensure the right team member with the right skills completes tasks safely and efficiently.
2. Staff	Standards met	2.2	Good practice	The pharmacy has robust systems in place for supporting the learning needs of its team members through continual learning and structured feedback. And the pharmacy team members make use of the tools available to improve their knowledge and skills .
3. Premises	Standards met	N/A	N/A	N/A
4. Services, including medicines management	Standards met	4.2	Good practice	The pharmacy works well with other healthcare professionals. And it has good risk strategies in place for the services it provides. This means people receive a safe and efficient service. And they receive valuable care and support to effectively manage their health and wellbeing.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance ✔ Standards met

Summary findings

The pharmacy has systems in place to help identify and manage the risks associated with its services. Pharmacy team members have clearly defined roles. And they effectively use audit tools and information within the pharmacy's procedures to make sure the right person with the right skills completes tasks safely and efficiently. Pharmacy team members act openly and honestly by sharing information when mistakes happen. And they engage in discussions about how to reduce risk following mistakes. They have the knowledge required to report safeguarding concerns to ensure the safety and wellbeing of vulnerable people is protected. The pharmacy keeps people's private information secure. It generally keeps all records it must by law. But some minor gaps in these records occasionally result in incomplete audit trails.

Inspector's evidence

The pharmacy had a set of up-to-date standard operating procedures (SOPs). The superintendent pharmacist's team reviewed these on a rolling two-year cycle. Pharmacy team members accessed SOPs electronically. And explained they watched an e-learning video, read the SOP and then completed an assessment to confirm their understanding of each SOP to inform their knowledge and learning. Training records confirmed that the team had read the SOPs. And pharmacy team members explained how they would go back to look at details of SOPs when something required clarification.

Pharmacy team members had job descriptions and the manager completed internal audits which helped to continually monitor compliance with SOPs. A member of the team explained what tasks could and couldn't be completed if the responsible pharmacist (RP) took absence from the premises. And she indicated the circumstances which she would need to refer to the pharmacist for advice. The pharmacy manager was an accuracy checking dispenser. He completed continual reflection of his work and followed revalidation processes which were supported by one-to-one meetings with a pharmacist. The pharmacy followed a clear process to ensure clinical checks of prescriptions were completed ahead of the dispenser undertaking an accuracy check. The dispenser explained how he informed all pharmacists of his training and had a clear understanding of the pharmacist's role in his own practice. And pharmacy technicians were given some additional responsibilities to help assist the manager and pharmacist in the day-to-day management of the pharmacy.

The pharmacy had moved premises to a brand-new building in February 2019. The new premises were smaller and pharmacy team members explained how they had adapted their working processes to fit in with the new environment. For example, the pharmacy sent some repeat prescriptions to its central hub as part of a hub and spoke model known as 'central fulfilment'. This had reduced the impact of moving to a smaller dispensary. The dispensary environment was clean and clutter free. The pharmacy team demonstrated how they used workspace effectively to manage risks during the dispensing process. Separate areas of the dispensary were used for completing acute and managed workload. And also, for labelling, assembly and final accuracy checking. A work bench to the side of the dispensary was used for completed tasks associated with the multi-compartmental compliance pack service. This reduced the risk of interruption during the dispensing process.

Pharmacy team members took ownership of their mistakes by discussing them with the pharmacist or

accuracy checking dispenser at the time they occurred. The team entered near-miss errors and dispensing incidents onto an electronic database (Datix). This provided both the pharmacy and the superintendent pharmacist's team with oversight of any mistakes made. The pharmacy routinely reported all dispensing incidents in this way. And it was driving improvements related to near-miss error reporting, as it had identified some gaps in reporting after the move to the new premises. Both near-miss error reports and incident reports included details of what had gone wrong. But the pharmacy did not always record the actions it had taken to prevent similar mistakes occurring. A pharmacy technician demonstrated the data entry process following a near-miss error being discovered. And the team had acted to review stock placement of the two medicines involved immediately following correction of the mistake.

The pharmacy had some patient safety review processes in place. These reviews had taken place monthly up to the move to the new premises. Following the move, the reviews had been completed every few months. The RP confirmed the team were getting back on track by aiming to hold the review each month. Completed templates clearly highlighted risks and actions taken to reduce them. For example, a CD balance checking schedule had been implemented following recognition that this was a task at risk of being missed during busy periods. And learning had been shared about 'look alike and sound alike' (LASA) medicines. Review templates were stored on a computer and as such did not visually engage the team. A discussion took place about making the template available for the team to refer to throughout the current month.

The pharmacy had a complaints procedure in place. And it provided details of how people could leave feedback or raise a concern about the pharmacy through a notice in the public area. A member of the team was observed handling feedback over the telephone during the inspection. The team member was professional and clearly established what the person's expectations were moving forward. And she took appropriate steps to ensure these expectations were met. The pharmacy engaged people in feedback through an annual 'Community Pharmacy Patient Questionnaire'. Results of the latest survey since moving premises was not yet available. But historic survey results relating to the old premises were clearly published on nhs.uk.

The pharmacy had up to date indemnity insurance arrangements in place. The RP notice contained the correct details of the RP on duty. Entries in the responsible pharmacist record complied with legal requirements. The sample of the controlled drug (CD) register examined was compliant with legal requirements. The pharmacy maintained running balances of CDs and these were generally checked weekly against physical stock. A physical balance check of Medikinet 5mg tablets complied with the balance in the register. The pharmacy maintained a CD destruction register for patient returned medicines. And the team entered returns in the register on the date of receipt. There was a few pages of returns awaiting destruction at the time of inspection, most of these had been received within the last month. The pharmacy kept records for private prescriptions and emergency supplies within its Prescription Only Medicine (POM) register. Some entries relating to private prescriptions did not contain both the date of prescribing and date of dispensing as required. Emergency supply records conformed to legal requirements. The pharmacy retained completed certificates of conformity for unlicensed medicines. But some audit trails on these certificates were missing. The manager confirmed this had been recognised as a recent learning point following an internal audit. And he had plans to complete learning with pharmacy team members about the Medicine & Healthcare products regulatory Agency (MHRA) record keeping requirements for unlicensed medicines.

The pharmacy displayed details of how it protected people's private information. Pharmacy team members completed regular information governance training. And this included additional learning following the introduction of the General Data Protection Regulation (GDPR). They were knowledgeable

about the requirements to protect people's confidentiality and demonstrated how they did this through their working processes. The pharmacy had submitted its annual NHS Data Security and Protection (DSP) Toolkit as required. The pharmacy had a contract in place with a reputable waste management company for the secure destruction of confidential waste.

The pharmacy had procedures and information relating to safeguarding vulnerable adults and children. All staff had completed e-learning on the subject and pharmacy professionals had completed level two learning. Pharmacy team members spoken to about safeguarding were knowledgeable about how to recognise and report concerns. The pharmacy's delivery driver provided several examples of how he had recognised and reported a concern. The pharmacy team had followed up on these concerns to ensure people's safety and wellbeing was maintained. The pharmacy had up-to-date contact information for safeguarding teams available.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough skilled and knowledgeable people working to provide its services safely. It has robust systems in place for supporting the learning needs of its team members through continual learning and structured feedback. And the team members use the tools available to improve their knowledge and skills. The pharmacy promotes how its team members can provide feedback. And it listens to their feedback and acts on it appropriately. Pharmacy team members engage in regular conversations relating to risk management and safety.

Inspector's evidence

On duty at the time of the inspection was the RP (full-time regular pharmacist), the pharmacy manager (an accuracy checking dispenser), three pharmacy technicians, a qualified dispenser and the delivery driver. The pharmacy also employed another dispenser and a trainee dispenser. The pharmacy had not replaced a member of the team who had left some months ago as other members of the team covered these hours as overtime. The team was due to meet to discuss changes to hours following the successful implementation of the central fulfilment service which had reduced dispensing levels in the pharmacy.

The trainee dispenser was enrolled on an accredited combined training course. Pharmacy team members were committed to ongoing learning. This included the completion of regular e-learning modules and attendance at local pharmaceutical committee events. Pharmacy team members received time in work to complete learning and could demonstrate how their learning had informed their practice. For example, they had used videos and guidance relating to the central fulfilment service to inform discussions and dispensing processes within the pharmacy. One member of the team explained how she had previously enjoyed attending face-to-face learning hosted by CPPE prior to venue changes which meant the events were no longer easily accessible. The pharmacy had a structured appraisal process which provided its team members with the opportunity to reflect and review their learning and development.

Pharmacy team members were observed listening to people’s needs and referring on to the pharmacist when required. The RP also managed several requests for advice over the telephone during the inspection. And he was heard confirming the advice he had provided to the person and checking they were happy with this prior to ending each call. This allowed people the opportunity to make an informed decision about their care and meant they could ask any further questions if needed. The pharmacy did have some targets in place to support the delivery of its services. Pharmacy team members supported pharmacists in the delivery of these services by identifying people who were eligible for a service during the dispensing process. Pharmacy team members demonstrated how some targets focussed on improving accessibility and convenience to people using the pharmacy. For example, offering the text messaging service to inform people when their medicines were ready for collection. The RP discussed how he applied his professional judgement when delivering services.

The pharmacy team mainly communicated through small informal briefings with two to three people at a time. Full staff meetings were held out of hours when there was important changes to communicate. But the pharmacy did not regularly record details of discussions to help inform shared learning and

reflection. The pharmacy had a whistleblowing policy in place. Pharmacy team members explained they were confident in sharing feedback or raising concerns if required. And they could provide examples of how their concerns had been listened to and taken seriously. Some members of the pharmacy team discussed how they had required some extra support since moving to the new premises. And this was due to several factors, outside of the team's control. Pharmacy team members were positive when speaking about the level of support they received from their manager and the regular pharmacist.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean, secure and maintained to the standards required. People using the pharmacy can speak with a member of the pharmacy team in confidence in a private consultation room.

Inspector's evidence

The pharmacy was located in a new build premises and formed part of a community multiservice centre. Other organisations operating from the building included the community policing team, a GP surgery and the village library. The pharmacy was professional in appearance and it was secure. The public area was accessible to people using wheelchairs and pushchairs. There was a clearly sign-posed consultation room. The room was a good size and professional in appearance. And pharmacy team members used the room with people requiring a private conversation.

The dispensary was a sufficient size for the level of activity carried out. And pharmacy team members managed work space well. Work benches were free from clutter. The pharmacy team had created an area for the storage of larger assembled medicines. This meant that floor spaces were free of any trip or fall hazards. To the side of the dispensary was a staff break area and staff facilities.

Pharmacy team members reported maintenance issues to a designated support desk. There were no outstanding maintenance issues at the time of inspection. The pharmacy was clean throughout, all team members contributed to cleaning tasks. The pharmacy had air conditioning, and lighting throughout the premises was bright. Antibacterial soap was readily available at designated hand washing sinks. And antibacterial hand sanitiser was also readily available.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy advertises its services and ensures these are accessible to people. The pharmacy works well with other healthcare professionals. And it has good risk strategies in place for the services it provides. This means people receive a safe and efficient service. And they receive valuable care and support to effectively manage their health and wellbeing. The pharmacy team demonstrates how it applies risk management strategies when providing its services. It obtains its medicines from reputable sources. And it stores and manages medicines appropriately.

Inspector's evidence

The pharmacy was accessed through automatic doors at street level. Details of its opening times and services were clearly advertised. The area immediately outside the pharmacy was benefitting from extensive works as part of the ongoing regeneration project. Pharmacy team members had worked with local contractors to ensure access arrangements into the pharmacy remained clear to people throughout these works. The pharmacy had a hearing loop. Pharmacy team members promoted its text messaging services by asking people to consent to the service if they wanted to receive text messages when their medication was ready for collection. And the delivery service was available to people who could not physically access the pharmacy to collect their medication. Seating was provided for people wishing to wait for prescriptions or services. The pharmacy team members were knowledgeable about how to refer people to other pharmacies or health services. They explained how they could use the internet or their own local knowledge to do this.

The pharmacy supported national health campaigns by promoting these to people using the pharmacy. And it had a range of health and service information leaflets available for people to take. It was participating in a pilot NHS heart health scheme by offering blood pressure checks which also detected atrial fibrillation (AF). The pilot involved onward referral for cases where AF was detected. Pharmacy team members felt they had a good working relationship with the surgery and explained how this assisted people in receiving timely access to their medicines. For example, the RP regularly shared details of out-of-stock medicines and provided details of suitable alternatives which were available. The pharmacy promoted self-care and a pharmacy team member explained how she had shared information with other team members about communication she had seen in the surgery about some medicines no longer being available on prescription due to their availability to purchase from pharmacies. This helped the team to prepare for providing support to people requiring these medicines. The pharmacist had been invited to speak at the surgery's next patient participation group about the role of pharmacies supporting access to self-care. The RP had conducted an informal audit of the outcomes of signposting people to their GP after they had attended for some advice about insect bites. The audit had helped to confirm the referrals had been warranted and had resulted in all referrals resulting in a prescription for either antibiotic treatment or prescription strength steroid creams.

The pharmacy had an up-to-date and legally valid patient group direction (PGD) for the supply of emergency hormonal contraception. The RP explained he had printed the NHS PGD for the upcoming flu vaccination service to support the pharmacy in preparing for the service. Pharmacy team members demonstrated an understanding of the risks associated with dispensing high-risk medicines. And they identified these medicines by attaching stickers to prescription forms and bags of assembled medicines.

This prompted referral to the pharmacist for counselling. The RP confirmed verbal counselling took place. But the details of these conversations were not generally recorded on people's medication records unless intervention was required. The pharmacy participated in the valproate pregnancy prevention programme (PPP) and PPP warning cards were available to issue to people in the high-risk group.

The team had completed training and competency tests prior to sending prescriptions to the company's hub as part of its central fulfilment service. Workflow and risks associated with this service were well managed. Several members of the team demonstrated different parts of the process. For example, the RP provided examples of prescriptions which met, and which didn't meet the criteria for sending to the hub. And he clearly explained the hub's processes. The accuracy of the information and clinical check was completed by the pharmacist prior to prescriptions being sent. Random 'Post-hub' checks were also in place. This required the pharmacist to physically check what the hub had dispensed. Near-miss error reporting processes were in place for the service and any concerns were shared with the team at the hub. The pharmacy team used a designated section of shelving in the dispensary for part-prescriptions (when some of the medicines on a prescription were dispensed locally and others by the hub). It had robust arrangements in place for matching any hub items to locally dispensed items prior to transferring them to the collection/delivery shelves. The RP explained this process meant he applied a second clinical check of the whole prescription when accuracy checking the locally dispensed items. And it meant the risk of people attending the pharmacy and only being given part of their prescription was greatly reduced. Pharmacy team members demonstrated how they used the computer system and an electronic tracking device throughout the dispensing process. The device provided information relating to the status and location of the prescription and any assembled medication, from it being entered on the system to the assembled medication being physically handed-out to a person.

The pharmacy used a planner to support workload associated with the multi-compartmental compliance pack service. Individual profile sheets were in place for each person on the service. And communication sheets assisted with managing queries. A pharmacy technician demonstrated how the team clearly documented changes to medication regimens within the person's profile. Pharmacy team members applied caution and undertook additional checks when titrating or reducing doses of medicines assembled in multi-compartmental compliance packs. A workload tracker identified who had completed each part of the dispensing process. This tracker included the clinical check of the prescription. A sample of assembled packs contained full dispensing audit trails. The pharmacy provided descriptions of the medicines inside the pack to help people identify them. And it supplied patient information leaflets at the beginning of each four-week cycle of packs.

The pharmacy used coloured baskets throughout the dispensing process. This kept medicines with the correct prescription form and helped inform workload priority. Pharmacy team members signed the 'dispensed by' and 'checked by' boxes on medicine labels to form a dispensing audit trail. The pharmacy team kept original prescriptions for medicines owing to people. The team used the prescription throughout the dispensing process when the medicine was later supplied. It maintained delivery audit trails for the prescription delivery service and people signed to confirm they had received their medicine. The pharmacy had a robust audit trail for the prescriptions it ordered from the surgery. It kept details of what was ordered. The surgery returned the repeat slips and annotated any relevant notes on the slips. Such as details of reviews that were due or details of why a prescription could not be issued. This meant the team could manage queries and speak to people if necessary prior to the person requiring their medicine.

The pharmacy sourced medicines from licensed wholesalers and specials manufacturers. Pharmacy team members demonstrated a good awareness of the aims of the Falsified Medicines Directive (FMD).

The pharmacy's clinical software programme had been upgraded and the team were aware this was in preparation for FMD. Pharmacy team members had access to training on the subject. But the pharmacy had not been informed of any dates relating to when FMD compliant processes would go live.

The pharmacy stored Pharmacy (P) medicines behind the medicine counter. This meant the RP had supervision of sales taking place and was able to intervene if necessary. The pharmacy stored medicines in the dispensary in an organised manner. And medicines were generally stored within their original packaging. But a box of gabapentin 100mg capsules was found to contain more capsules than its original pack size indicated. Pharmacy team members acknowledged this practice had been brought to their attention and recognised the risks associated with storing medicines in this way. They acted immediately to ensure only medicines which matched the batch number and expiry date remained in the box prior to returning it to the shelf. The remaining strips were segregated ready to dispose of safely. The team followed an electronic date checking rota to help manage stock. Short dated medicines were identified. And pharmacy team members annotated the opening date on to bottles of liquid medicines. This allowed them to apply checks during the dispensing process to ensure the medicine remained fit for purpose. No out out-of-date medicines were found during a random check of dispensary stock.

The pharmacy held CDs in secure cabinets. Medicines inside were kept in a safe and orderly manner. For example, different formulations of methadone solution were stored in separate cabinets. There was designated space for storing patient returns, and out-of-date CDs. Assembled CDs were held in clear bags with details of the prescription's 28-day validity period clearly indicated. Pharmacy team members were observed applying additional checks of these medicines prior to handing them out. The pharmacy's fridges were clean and stock inside was stored in an organised manner. Temperature records confirmed the fridges were operating between two and eight degrees Celsius as required.

The pharmacy had medical waste bins and CD denaturing kits available to support the team in managing pharmaceutical waste. The pharmacy received drug alerts through its intranet. The pharmacy team demonstrated how an audit trail was created once an alert was read and actioned. All alerts were up to date at the time of inspection.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs for providing its services. Pharmacy team members manage and use equipment in ways which protect people's confidentiality.

Inspector's evidence

The pharmacy had up-to-date written reference resources available. These included the British National Formulary (BNF) and BNF for Children. Pharmacy team members also had access to the internet and intranet which provided them with further resources. The pharmacy's computers were password protected and information on computer monitors was protected from unauthorised view due to the layout of the pharmacy. The pharmacy stored assembled bags of medicines to the side of the dispensary, out of direct sight of the public area. This protected people's private information on prescriptions and bag labels from unauthorised view. Pharmacy team members used NHS smart cards to access people's medication records. And they used cordless telephone handsets. This meant they could move out of ear-shot of the public area when having confidential conversations with people over the telephone.

Clean, crown stamped measuring cylinders were in place for measuring liquid medicines. And these included a separate measure for use with methadone. The pharmacy had clean counting equipment for tablets and capsules, including a separate counting triangle for use when counting cytotoxic medicines. The pharmacy had two working blood pressure machines. One machine had been supplied specifically to detect AF as part of the NHS pilot service. The pharmacy had the necessary equipment readily available to support the supply of medicines in multi-compartmental compliance packs. Stickers on electrical equipment showed portable appliance checks had last been carried out in November 2018. Pharmacy team members were aware of electrical safety checks taking place prior to them moving into the new premises in February 2019.

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.