General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Whitworth your family pharmacy, 13-15 Lumley Road, Skegness, Lincolnshire, PE25 3LL

Pharmacy reference: 9011112

Type of pharmacy: Community

Date of inspection: 11/11/2019

Pharmacy context

This is a community pharmacy in a popular seaside resort town on the Lincolnshire coast. The pharmacy relocated from former premises to the main shopping street in the town in early 2019. The pharmacy sells over-the-counter medicines and dispenses NHS prescriptions and private prescriptions. It offers advice on the management of minor illnesses and long-term conditions. It supplies medicines in multi-compartment 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

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 met	N/A	N/A	N/A
2. Staff	Standards met	N/A	N/A	N/A
3. Premises	Standards met	3.2	Good practice	Pharmacy team members actively promote the use of the pharmacy's consultation spaces. And the consultation room is fitted to a high standard.
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 identifies and manages the risks associated with its services. It keeps people's private information secure. The pharmacy has appropriate arrangements in place for managing feedback and concerns. Its team members have the knowledge required to recognise and report a concern to safeguard the safety and wellbeing of vulnerable people. Pharmacy team members act openly and honestly by sharing information when mistakes happen. And they can demonstrate the changes they make to help improve patient safety. The pharmacy generally keeps the records it must by law. But due to a technical issue the pharmacy has gaps in the record used to identify who the responsible pharmacist is at any given time. This means the pharmacy may find it difficult to respond to a query relating to the responsible pharmacist should one arise.

Inspector's evidence

The pharmacy had a set of written standard operating procedures (SOPs) available in the dispensary. The pharmacy was in the process of transferring all recently reviewed SOPs and training records associated with SOPs to an electronic system. A newer member of the team had begun reading and signing off the new version of SOPs. And training records belonging to other members of the team were available in hard copy. The SOPs were reviewed at two-year intervals. And they included the roles and responsibilities of pharmacy team members. Pharmacy team members were observed working in accordance with dispensing SOPs during the inspection. And a member of the team discussed what tasks could and could not take place if the responsible pharmacist (RP) took absence from the pharmacy.

Pharmacy team members managed workflow well. There was clearly designated areas for labelling, assembly and accuracy checking in the dispensary. Acute prescriptions were labelled and assembled close to the front of the dispensary and managed workload was completed on a different workbench. There was good space for managing tasks associated with the multi-compartment compliance pack service. The pharmacy team was in the process of increasing this space further as its workload had recently changed. This change had seen a sharp rise in the number of people accessing the pharmacy's multi-compartment compliance pack and delivery service. The RP was a company employed relief pharmacist. She explained she had recently contacted surgeries to discuss processes for assessing people's needs prior to dispensing medicines into multi-compartment compliance packs. This was to help ensure providing medicines in this way was the best option to support people in managing their medicines.

The pharmacy had a near-miss error reporting procedure. Pharmacy team members explained they had experienced a busy summer period and had recognised this had led to them managing some near misses through discussing and correcting the mistake only. This meant not all near misses were recorded and there may have been some missed learning opportunities. Near-miss error rates had risen recently, and pharmacy team members felt this was due to the improved consistency in recording their mistakes. The pharmacy team members engaged in a monthly patient safety review which involved identifying trends in mistakes and implementing risk reduction actions to help reduce risk across the dispensary. Recent actions had included the use of 'Tall Man' lettering on shelf edges for 'look-alike and sound-alike' (LASA) medicines. This helped prompt additional checks during the dispensing process.

Different formulations of the same medicine had also been separated on the dispensary shelves. For example, ramipril tablets and capsules. And a pharmacy team member explained how eye drops had been relocated in the dispensary as concerns were raised about the difficulty in reading the information on boxes during the picking process. This had been due to the eye drops being located on a low shelf.

The pharmacy reported its dispensing incidents through an electronic system. This provided the pharmacy's area manager and superintendent pharmacist with an oversight of the mistakes made. The RP explained how she would manage and seek to resolve a dispensing incident. This process included checking the expectations of the person affected by the error, apologising, correcting the mistake and reporting the incident. The RP explained the company's warehouse were proactive to feedback. For example, if a pharmacy felt there was higher-risk of error due to LASA medicines they would seek to send different brands to the pharmacy.

The pharmacy advertised its complaints procedure in its practice leaflet. And a leaflet at the pharmacy counter invited people to leave a 'Google review' for the pharmacy. Pharmacy team members explained how they would manage and escalate a concern to the pharmacist in the first instance. And they explained during the summer there had been periods where queues had formed due to the number of both local residents and tourists visiting the pharmacy. They explained how they had used feedback from this experience to help them plan their workload.

The pharmacy had up-to-date indemnity insurance arrangements in place. The RP notice displayed contained the correct details of the RP on duty. The RP record was kept electronically. The sample of the RP record examined was not compliant with legal requirements as the sign-out time of the RP was frequently missing. The RP on duty confirmed she had been signing out of the record as she left in an evening. Following the inspection, the RP provided confirmation that the team had monitored the signing-out process for the remainder of the week. And a fault in the record not appearing despite being made was found. The issue had been reported to the IT support team and daily monitoring of the issue to find the cause was being taken. The RP confirmed a notice at the front of the dispensary had also been put up to help remind pharmacists to sign-out of the record.

The pharmacy maintained running balances of controlled drugs (CDs) within its CD register. The register was kept in accordance with legal requirements. The pharmacy completed full balance checks on average a couple of times each month. The balance checks had increased in frequency more recently. A physical balance check of Physeptone 5mg tablets complied with the balance of the CD register. The pharmacy maintained a patient returned CD register. And pharmacy team members wrote schedule two returns into the register on the date of receipt. Some pregabalin capsules were found in a CD cabinet waiting to be destroyed on the date of inspection. The returns were clearly marked. The pharmacy kept records associated with the supply of unlicensed medicines in accordance with the requirements of the Medicines & Healthcare products Regulatory Agency (MHRA). And it kept records in the Prescription Only Medicine (POM) register up to date. One recent entry for a private prescription made in the POM register did not contain the prescriber's address. This was brought to the attention of the RP.

The pharmacy displayed a privacy notice. It had procedures relating to information governance and compliance with data protection requirements. Pharmacy team members discussed the need to maintain people's confidentiality and explained how they would offer the consultation room to people who required a private conversation with a member of the team. The pharmacy had some evidence of information governance audits being carried out. But those seen related to its previous premises. It stored all personal identifiable information in staff only areas of the pharmacy. And it used a heavy-duty shredder to dispose of its confidential waste.

The pharmacy had procedures and information relating to safeguarding vulnerable adults and children. And the pharmacy had contact information for safeguarding agencies. Pharmacy team members on duty explained they had completed safeguarding learning in their previous roles. And these roles had been in either community pharmacy or GP dispensing practices. The RP had completed level two safeguarding training through the Centre for Pharmacy Postgraduate Education (CPPE). A pharmacy team member was confident in explaining how she would recognise and report a safeguarding concern. The delivery driver on the date of inspection was an agency driver. He was observed feeding back concerns about a person who was potentially non-compliant with their medicine regimen.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy employs qualified and skilled people to provide its services. Pharmacy team members take part in regular conversations relating to risk management and safety. And they have the confidence to follow the pharmacy's staff feedback processes should they need to. The busy seasonal period has provided the pharmacy with some opportunities to review and improve the way it manages it workload. And pharmacy team members are seen to engage with these new ways of working. They have access to the relevant learning to support them in their roles. But they have not always received time to support them with this learning.

Inspector's evidence

On duty throughout the inspection was the RP, two qualified dispensers and a trainee dispenser. The pharmacy's manager was on pre-planned long-term leave). The pharmacy also employed another qualified dispenser and delivery driver. The delivery driver was on leave and this service was being covered by an agency driver throughout the week. Pharmacy team members were observed briefing the driver about the requirements of the delivery service, including the requirement to obtain a signature from people upon delivery of the medication via the electronic point of delivery (EPOD) device.

All pharmacy team members had started working in the pharmacy after its relocation. One member of the team was still within her induction period. The manager had also commenced her role following the move. The RP on duty had worked for the company for a couple of months. She was knowledgeable about the company's procedures and processes. And demonstrated enthusiasm for her role. All members were observed working well together and supporting each other throughout the inspection. The RP explained the pharmacy's target was to serve the public. And demonstrated through conversation how she applied her professional judgement when delivering services. For example, when providing the new NHS Community Pharmacist Consultation Service (CPCS).

Pharmacy team members who had worked at the pharmacy over the busy summer period explained it had been a difficult time. This was due to a member of the team leaving and the increased workload experienced. They explained they were aware of how to report and escalate a concern if required. And a member of the team confirmed she would report concerns if she felt a situation meant the pharmacy was unsafe. Pharmacy team members explained how they were currently being supported through the company providing relief pharmacists when it could to cover the managers leave. The RP on duty was working a block of shifts in the pharmacy. And she explained how this was working well as she could assist the team in implementing new ways of working to help manage workload. For example, the pharmacy had implemented a task matrix to help ensure all team members were confident in completing a variety of tasks to support the delivery of its services. And a daily task sheet for pharmacists had been created to ensure key tasks associated with the safe running of the pharmacy were completed.

The pharmacy had a whistleblowing policy. And pharmacy team members confirmed they knew how to escalate a concern about the pharmacy if required. They provided some examples of how their ideas were recognised. For example, feedback from its team members had been used to adapt workflow and

make changes to the layout of the dispensary. The pharmacy team shared information relating to workload management through informal discussions on a daily basis. Pharmacy team members explained they gathered for a team briefing at the end of the month to share learning relating to patient safety. There were some notes made following these briefings. But the briefings were not displayed for the pharmacy team members to refer to and reflect upon.

The trainee dispenser was enrolled on a GPhC accredited training course. She had worked as a medicine counter assistant in her previous role. The trainee confirmed she received support with her learning. But she had only very recently been provided with some time at work to assist her in completing her training. The RP had helped to facilitate this learning time. Pharmacy team members were in the process of beginning continual learning to support them in their roles. This learning had been delayed due to the busy summer period. But the RP had worked with the team to plan some training. For example, CPPE LASA medicine e-learning and a safeguarding refresher were due to be completed.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean and secure. It offers a professional environment for delivering healthcare services. Pharmacy team members actively promote the use of the pharmacy's consultation spaces. And the consultation room is fitted to a high standard.

Inspector's evidence

The pharmacy was located on a busy shopping street. It was secure and well maintained. Pharmacy team members could report maintenance concerns to their head office. A recent request to fit some type of barrier to the side of the medicine counter had been acknowledged. And a maintenance team had attended to assess the work required. The pharmacy was bright and clean throughout. Antibacterial hand wash and paper towels were available at sinks. The pharmacy had appropriate air-conditioning and heating arrangements.

The public area was fitted with wide spaced aisles. A feature wall in this area depicted a beach and seafront. The consultation room door opened from a beach hut in the scene. This provided a cheerful and unique environment in the public area of the pharmacy. It also helped to provide a relaxing atmosphere for people visiting the pharmacy for services such as flu vaccinations. The dispensary was a good size. The team utilised space well and kept workbenches and floors free from clutter. To the back of the dispensary was a small staff room and staff toilet facilities.

The consultation room was a good size. It was clearly sign-posted and fitted to a high standard. It was clear of clutter and was professional in appearance. The room was protected from unauthorised access when it was not in use. And equipment to support the delivery of services was available close to hand. For example, anaphylaxis supplies. The RP was observed inviting people into the room to hold private conversations. The pharmacy also had a semi-private hatch leading from the back of the public area to the side of the dispensary. The hatch provided a suitable space for the pharmacy's supervised consumption service.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy advertises its services and it makes them accessible to people. It obtains its medicines from reputable sources. And it has systems to ensure it stores its medicines safely and securely. The pharmacy team members follow written procedures to help them deliver pharmacy services safely and effectively. And they provide relevant information to people about their medicines.

Inspector's evidence

The pharmacy's external signage was professional and clear. And the pharmacy advertised its opening times and services in window displays. Access into the pharmacy was through a push/pull door from street level. A prominent display relating to the seasonal flu vaccination service met people who entered the pharmacy. And this service was delivered several times during the inspection. The pharmacy had up-to-date and legally valid patient group directions (PGDs) to support pharmacists delivering this service.

A dispenser highlighted an area to the side of the medicine counter where the pharmacy usually displayed details of national health campaigns. The campaign for October relating to 'Stoptober' had been taken down. And the November display was waiting to be put up in its place. The dispenser had taken time to research local support groups and mental health charities ahead of the November campaign. And explained how health campaigns prompted team members to learn more about the conditions associated with the campaigns. A plan of how the campaign was to be displayed was amongst the display material on a dispensary work bench.

The RP was observed making herself available to talk to people about their medicines. And discussed the outcome of some services she had provided whilst working at the pharmacy. For example, assisting people in accessing their medicines in an emergency through the CPCS service. Pharmacy team members were aware of sign-posting requirements should the pharmacy be unable to provide a service or medicine.

Pharmacy team members provided examples of how they identified higher-risk medicines such as warfarin and methotrexate. And the pharmacy had stickers which they placed on assembled bags of medicines to highlight the need for counselling. The pharmacy recorded some details of the interventions and counselling it provided to these people. Pharmacy team members were aware of the requirements of the valproate pregnancy prevention programme (PPP). The RP explained she had identified the pharmacy had not recently dispensed any valproate to people in the high-risk group. The pharmacy had information and valproate warning cards available if it received a prescription for a person in the high-risk group. And the RP was aware of where she could access further support materials. The pharmacy identified prescriptions for CDs by highlighting the information on the prescription. And it stored assembled CDs and cold chain medicines in clear bags. This prompted additional checks upon supply.

All pharmacy team members could complete tasks associated with the multi-compartment compliance pack service. The pharmacy used a diary to help plan its workload for the service and managed the work on a four-week rolling rota. Pharmacy team members had recently increased the type of information

recorded in the diary to help ensure messages from surgery teams were clearly recorded. Packs were being assembled a few days prior to them being due for collection or delivery. Individual profile sheets were in place for each person on the service. And the team generally used these well to track changes to medication regimens. Some sheets did not include the formulations of the medicines inside the packs. 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. But backing sheets on the sample of packs examined did not include adverse warning as required. A discussion took place about the risks of dispensing medicines without these warnings. Following the inspection, the RP provided confirmation that the IT settings had been updated to include these warnings.

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. Separate baskets on a designated work bench were assigned for managing queries and owings. The pharmacy team kept original prescriptions for medicines owing to people. And it used the prescription throughout the dispensing process when the medicine was later supplied. A dispenser was observed calling a wholesaler to try and obtain a date of availability for a medicine which had been out of stock.

The pharmacy sourced medicines from the company's own warehouse, licensed wholesalers and specials manufacturers. The pharmacy had a stand-alone scanner to assist in complying with the requirements of the Falsified Medicine Directive (FMD). And the RP confirmed the pharmacy was registered with SecurMed. She explained FMD processes had recently been demonstrated at a company conference. And the pharmacy had gone through small periods where its team members had trialled the system. Pharmacy team members had access to an online video to support them in using the system. But they were not routinely scanning medicines. Pharmacy team members could discuss changes to medicine packaging associated with FMD requirements. For example, tamper-proof seals. The pharmacy received MHRA drug alerts and recalls electronically. And it kept details of the alerts it had actioned. The alerts were included in the monthly patient safety review.

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. Most medicines were stored in original packaging. But a packet of ciprofloxacillin 500mg tablets with 30 tablets inside was found on the dispensary shelves, the original pack size advertised was ten tablets. And a couple of amber bottles containing medicines were found on the shelves. The labels did not contain the full details of the medicine stored inside. For example, the manufacturer and the date of original assembly. These were brought to the attention of the RP after the inspection. And the RP provided assurance she would provide feedback to the team about these findings. The pharmacy team followed a date checking rota to help manage stock and it recorded details of the date checks it completed. Short-dated medicines were identified and the team annotated details of opening dates on bottles of liquid medicines. No out-of-date medicines were found during checks of dispensary stock. Medical waste bins, sharps bins and CD denaturing kits were available to support the team in managing pharmaceutical waste.

The pharmacy held CDs in secure cabinets. Medicine storage inside the cabinets was orderly. There was designated space for storing patient returned, and out-of-date CDs. The pharmacy used two fridges to store its cold chain medicines. One fridge held smaller items and assembled items and the other held larger items such as insulin pens. Both fridges were clean. And medicines inside were stored in an orderly manner. The pharmacy team monitored fridge temperatures. But records had some gaps where fridge temperatures had not been recorded. Records either side of these dates confirmed the

temperature of the fridges had remained between two and eight degrees Celsius as required. The RP confirmed she would share this information with team members to help ensure the fridge temperature monitoring was recorded daily.

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 the equipment in a way which protects people's confidentiality.

Inspector's evidence

Pharmacy team members had access to up-to-date written reference resources. These included the British National Formulary (BNF) and BNF for Children. Internet access provided further reference resources. The pharmacy had clean, crown stamped measuring cylinders for measuring liquid medicines. Cylinders for use with methadone were clearly marked. Counting equipment for tablets and capsules was available. There was a blood pressure machine in the consultation room. The machine was reported to be new and it was used for screening purposes only. The pharmacy held equipment to support the seasonal flu vaccination service within its consultation room. Equipment used for the multi-compartment compliance pack service was single use and it was stored appropriately. As were dispensary sundries such as bottles and bags. The pharmacy had some equipment to support dispensing to care homes. The team confirmed the service had been provided to one care home, this service had very recently stopped. The pharmacy's electrical equipment was free from wear and tear.

Computers were password protected and faced into the dispensary. This prevented unauthorised view of information on computer screens. Most pharmacy team members had working NHS smart cards. The pharmacy stored assembled bags of medicines waiting for collection and delivery on shelves in the dispensary. Personal information on bag labels could not be seen from the public area. The pharmacy had cordless telephone handsets. Pharmacy team members moved to the back of the dispensary, out of ear shot of the public, when speaking with people on the phone.

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.