General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Evans Pharmacy, Charles Street, Ruddington, Nottingham, Nottinghamshire, NG11 6EF

Pharmacy reference: 9011156

Type of pharmacy: Community

Date of inspection: 05/12/2019

Pharmacy context

This community pharmacy is in a village on the outskirts of Nottingham. The pharmacy relocated from its former premises within the village in Spring 2019. The pharmacy sells over-the-counter medicines and it dispenses NHS and private prescriptions. The pharmacy 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 provides a medicines delivery service 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	1.8	Good practice	The pharmacy promotes a clear culture of safeguarding the safety and wellbeing of vulnerable people. It considers the needs of these people and how it can work to support them in taking medicines. And it shares details of concerns with surgery teams appropriately.
2. Staff	Standards met	2.5	Good practice	The pharmacy promotes how its team members can provide feedback. And its team members are knowledgeable about how to provide feedback or raise a concern if needed. The pharmacy acts on this feedback to improve workflow and specific learning requests.
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 identifies and manages the risks associated with its services. It keeps people's private information secure. And it keeps all records it must by law. The pharmacy advertises how people can feedback about its services and it responds appropriately to the feedback it receives. The pharmacy promotes a clear culture of safeguarding the safety and wellbeing of vulnerable people. It considers the needs of these people and how it can work to support them in taking medicines. And it shares details of concerns with surgery teams appropriately. Pharmacy team members act openly and honestly by sharing information when mistakes happen. And they demonstrate how they learn from their mistakes.

Inspector's evidence

The pharmacy had a set of written standard operating procedures (SOPs). These included responsible pharmacist (RP) requirements, controlled drug (CD) management and services. The SOPs had been implemented at various dates and they contained details of a two-yearly review. But the review date on some SOPs had passed. And the RP confirmed the pharmacy had not received any updated SOPs for those which had been due for review in October and November 2019. The SOPs highlighted the roles and responsibilities of pharmacy team members. But not all members of the team had signed all SOPs associated with their roles to confirm that they had read and understood them. The RP, who was the pharmacy manager, had identified this prior to the inspection. And it was seen to be on a list of tasks requiring completion. Pharmacy team members were confident when demonstrating and discussing some of their roles and responsibilities throughout the inspection. A relief pharmacist explained how she received SOP updates via email. And she signed these off when working at a specific pharmacy within the company. This meant that all her training records were held together.

Pharmacy team members explained how the new premises was notably larger than the pharmacy's previous premises. And they demonstrated how they managed dispensary workflow. 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 protected space on this bench was provided for the final accuracy check of medicines. Pharmacy team members completed managed workload associated with repeat prescriptions and multi-compartment compliance packs towards the back of the dispensary. And protected space on a workbench to the side of the dispensary was available for completing accuracy checks of these medicines.

The pharmacy had a near-miss error reporting procedure. Pharmacy team members were asked to look again at their work to try and identify their own mistakes. And they explained how this helped them identify learning opportunities and patterns in their mistakes. They corrected their own mistakes whenever possible and took responsibility for recording the near miss. Records confirmed that near miss reporting was consistent. There were peaks in mistakes when newer members of the team had begun training in the dispensary. But the records did not always identify factors contributing to mistakes. A discussion took place about the benefit of recording this information to help inform risk reduction actions and shared learning. The RP completed an analysis of near misses each month. And this was sent to the superintendent pharmacist's office. The team did not formally record the actions it took to reduce risk. This meant it might be more difficult for the pharmacy to monitor the effectiveness of these actions. But pharmacy team members were confident when discussing and demonstrating

recent actions taken to improve safety in the pharmacy. For example, the pre-registration pharmacist (pre-reg) explained learning associated with 'look-alike and sound-alike' (LASA) medicines. And examples of high-risk warning notes on shelf-edges were demonstrated. These notes helped prompt additional checks during the dispensing process.

The pharmacy reported its dispensing incidents through to the superintendent pharmacist's office. And the monthly analysis included details of these types of mistakes. There had been a rise in incidents within the last month. And the RP reflected on a change of staffing which may have contributed to this. Pharmacy team members were briefed of mistakes. And opportunities to learn from them were taken. For example, the pharmacy had reviewed its team's compliance with the processes for managing the multi-compartment compliance pack service following an incident. The pharmacy team had also separated sildenafil and sertraline on the dispensary shelves following an incident. And it had highlighted both of these medicines to prompt additional checks during the dispensing process.

The pharmacy advertised its complaints procedure in its practice leaflet. A pharmacy team member explained how she would manage and escalate a concern to the pharmacist in the first instance. And she stated that the pharmacy team strived to meet people's expectations at all times. The pharmacy also asked for feedback through its annual 'Community Pharmacy Patient Questionnaire'. And it published the results of this questionnaire for people to see.

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 in accordance with legal requirements. The pharmacy maintained running balances of CDs within its CD register. The register was kept in accordance with legal requirements. And the pharmacy kept running balances within the register. The pharmacy completed periodic full balance checks. But there was scope for these to be completed more frequently. Dates of the last balance checks for solid dose formulations were July 2019 and November 2019. The pharmacy had last completed a balance check of its methadone oral solution in September 2019. A physical balance check of Zomorph 10mg capsules complied with the balance recorded in the register. The pharmacy maintained a patient returned CD register. And pharmacy team members recorded returns into the register at the time of receipt. 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 in full. But entries in this record were routinely entered in weekly in batches rather than on the date of dispensing.

The pharmacy displayed a privacy notice. And it had published information available to people about how it looked after their private information. It had procedures relating to information governance and compliance with data protection requirements. Pharmacy team members discussed the need to maintain people's confidentiality. A member of the team explained how she would take swift action to remove any personal information left at the medicine counter. For example, a repeat prescription slip. The pharmacy stored most personal identifiable information in staff only areas. Some information was seen in a folder in the consultation room. The information was not on open display and pharmacy team members were able to monitor access to this area. The pharmacy collected its confidential waste in designated white sacks. These were sealed and sent for secure destruction via a waste management company.

The pharmacy had procedures and information relating to safeguarding vulnerable adults and children. And the pharmacy had contact information for safeguarding agencies readily available. Pharmacy team members had completed some learning relating to safeguarding through reading procedures and team discussions. And more training was seen to be planned. Pharmacists had completed level two learning

on the subject through the Centre for Pharmacy Postgraduate Education (CPPE). Pharmacy team members were confident in explaining how they would recognise and report a safeguarding concern. And explained how the team shared minor concerns with each other to allow them to monitor these. A team member explained how the RP had intervened appropriately by speaking to people when team members had raised concerns about frequent requests for opioid painkillers. The pharmacy had shared concerns relating to compliance with medication regimens with surgeries on occasion. And the RP completed formal assessments with people prior to them having their medicines supplied in multi-compartment compliance packs. This had provided the opportunity to discuss alternative ways the pharmacy could support people in taking their medication when the outcome of the assessment indicated there would be no benefit of changing the method of supply. For example, by supporting people with ordering repeat prescriptions. And the RP had followed up with some people who had started on a multi-compartment compliance pack to review if the pack was helping.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough skilled and knowledgeable people working to provide its services effectively. Pharmacy team members engage in regular conversations relating to risk management and safety. And they show how they implement risk reduction actions following this learning. The pharmacy promotes how its team members can provide feedback. And its team members are knowledgeable about how to provide feedback or raise a concern if needed. The pharmacy acts on this feedback to improve workflow and specific learning requests. It has systems for supporting the learning needs of its team members. But it does not provide protected learning time to all team members. And there are some gaps in training records associated with the pharmacy's procedures.

Inspector's evidence

On duty during the inspection was the RP, a second pharmacist, a pre-reg, a level three qualified dispenser, a qualified medicine counter assistant, a trainee medicine counter assistant and a delivery driver. The pharmacy also employed a level two dispenser, a trainee dispenser, a trainee medicine counter assistant and another delivery driver. A part-time accuracy checking technician had left the pharmacy recently. The RP explained that support for this role was currently being provided through the pharmacist relief team. The pharmacy was operating with two pharmacists on duty three days a week around the date of inspection. It also employed another level two dispenser on a zero hours contract. And the RP explained how this helped to manage annual leave and unplanned leave.

The pharmacy did not provide protected learning time to pharmacy team members on accredited training courses. But a trainee on duty at the time of inspection confirmed she felt supported in her role and could speak to the RP or other members of the team about her training when needed. The pre-reg did receive some protected training time. And this was taken throughout the week to support him in his learning. He confirmed that he felt fully supported and discussed how his role was progressing well. The pre-reg was aware of how to raise any concerns about his placement. And confirmed he would feel comfortable raising these with his tutor (the RP) in the first instance. Pharmacy team members could take some time in work for mandatory training, such as reading SOPs. But this was not always taken. The RP was working with team members to bring training records associated with SOPs up to date. There was some continual learning opportunities for team members. For example, the pre-reg discussed completing CPPE LASA learning. And another pharmacy team member discussed reading information and completing some learning associated with healthy living campaigns.

Pharmacy team members received an annual appraisal with the manager. And confirmed they could openly provide feedback between appraisals. Those on duty expressed feeling supported. The pharmacy did not hold structured team meetings. But smaller informal briefings took place periodically. The most recent team briefing had resulted in a 'to do' list being created to help team members focus on completing learning. The pre-reg explained how shared learning about the need to ensure team members were identifying split boxes in a confident manner had been discussed during the team briefing. He explained how the RP had highlighted the risks of accidentally supplying the wrong quantity of medicine if the process for identifying split packs was not followed correctly. The pharmacy had a whistleblowing policy in place. Pharmacy team members were confident at explaining how they would share concerns with the RP in the first instance. And were aware of how to escalate concerns if

required. They had worked together to apply some changes to the dispensary workflow when settling into the new premises. The pre-reg shared some examples of feedback about learning he wished to focus on. And the RP had worked with others in the company to set up a plan to facilitate this learning.

The RP provided details of some of the annual targets the pharmacy was given to meet. These included completing New Medicine Service (NMS) consultations and Medicines Use Reviews (MURs). The pharmacy sent details of its completed services to its superintendent's office each month. And the RP explained clearly how he was able to apply his professional judgement when delivering services. He managed targets by breaking them down into monthly mini targets. And explained how this helped monitor delivery of these services. The pharmacy regularly met its targets. The relief pharmacist discussed how she worked with pharmacy teams to highlight people who may benefit from services. And discussed how she applied her professional judgement when delivering services.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean and secure. It offers a professional environment for delivering healthcare services. People using the pharmacy can speak with a member of the pharmacy team in confidence in a private consultation room. And pharmacy team members promote the use of this room.

Inspector's evidence

The pharmacy was secure, and it provided a professional image to people visiting. The public area was open plan and fully accessible. To the side of the public area was a door leading through to a store cupboard and a good size consultation room. This room offered a clinical environment for providing services such as vaccinations. And it was appropriately equipped with suitable equipment and information to support these services. For example, a copy of the enhanced minor ailments protocol was readily available for the RP to refer to during consultations. The RP was observed using the room with people attending the pharmacy during the inspection.

The dispensary was a suitable size for the level of activity undertaken. There were designated workbenches for managing acute workflow, repeat prescriptions and activities associated with the multi-compartment compliance pack service. And pharmacy team members commented positively about their working environment. Off the back of the dispensary was a hall way leading to a small storage room and a staff toilet. The stairs leading to the first-floor level of the premises led off this room. The first-floor level consisted of several large store rooms, office space and a staff kitchen.

The pharmacy was in maintained to a good standard and is was clean throughout. The team reported maintenance concerns to its head office. Work benches and floor spaces were clear of clutter. Antibacterial hand wash and paper towels were available at designated hand washing sinks. The pharmacy had working air conditioning on the ground-floor level. And lighting throughout the premises was good.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy advertises its services and makes them accessible to people. It has procedures to support the pharmacy team in delivering its services. And its team follows these procedures. The pharmacy obtains its medicines from reputable sources. It stores medicines securely. And it makes appropriate checks to ensure medicines are safe to supply. People visiting the pharmacy receive effective advice. And the pharmacy identifies high-risk medicines to help make sure people taking these medicines have the support they need. But the pharmacy's processes do not ensure people receive patient information leaflets with their medicines supplied in compliance pouches. This means they may not always get all the information they need about their medicine.

Inspector's evidence

The pharmacy's external signage was professional and clear. And the pharmacy advertised its opening times and services in window displays. People accessed the pharmacy from either a concrete ramp with handrails or a set of steps. The pharmacy had a designated health promotion area. But pharmacy team members explained the information displayed did not regularly prompt discussions with people using the pharmacy. Pharmacy team members were aware of how to signpost people to another pharmacy or healthcare service if they were unable to provide a service. The RP explained how he had recently provided details of charities that were available to support carers through the MUR service.

The pharmacy had up-to-date and legally valid patient group directions (PGDs) to support pharmacists delivering this service. These PGDs included antibiotics for the extended minor ailments scheme. And the RP explained the additional training he had completed in order to provide this service. He also discussed some of the challenges he faced when managing people's expectations or receiving an antibiotic when one was not indicated. For example, when symptoms of a sore throat and an examination of the throat indicated a person had a viral infection rather than a bacterial infection. The RP clearly enjoyed engaging with people and providing services. And he explained how the pharmacy enjoyed a good working relationship with the GP surgery. For example, the surgery would signpost people to the pharmacy for travel health services and minor ailment consultations. The RP explained that NMS consultations for inhalers were often beneficial to people. As some people commencing on inhalers were not aware of the long-term requirement to take their medication.

The pharmacy offered a travel service which included vaccinations and antimalarials. These were prescribed by a company employed pharmacist independent prescriber (PIP). The PIP also prescribed medication for common conditions and minor ailments. For example, sildenafil for erectile dysfunction and period delay medication. The service was advertised as a suitable service for people who could not obtain a prescription from their GP due to changes in NHS prescribing policies. And the RP undertook a consultation with a person requesting the service. Details of this consultation were shared with the PIP before a decision to prescribe was made. The RP explained the service had only been used on a couple of occasions for these medicines. And was not used routinely as a route for bypassing people's regular GP. No high-risk medicines or medicine requiring monitoring had been dispensed through the service to date. Specific SOPs relating to how risks associated with providing services at a distance in this way were being managed.

Pharmacy team members demonstrated how they identified high-risk medicines. The RP provided a sample of individual record sheets that people taking warfarin were asked to complete. This allowed the RP to check the frequency of monitoring checks. The RP had identified a small number of people prescribed lithium through one of its current audits. He had spoken to a couple of people identified as part of this audit and had prompts in place to speak with others. 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). A recent valproate audit confirmed the pharmacy were not dispensing valproate to people in the high-risk group. But warning cards associated with PPP were available to issue to people if required. The pharmacy identified prescriptions for CDs by highlighting the information on the prescription.

All pharmacy team members could complete tasks associated with the multi-compartment compliance pack service. It had a clear system for identifying when prescriptions had been requested and when packs had been assembled. The pharmacy provided two types of packs to people. A traditional tray style multi-compartment compliance pack was assembled by the pharmacy. A sample of these packs contained clear descriptions of the medicines inside and full audit trails of those involved in the dispensing process. Patient information leaflets (PILs) were provided at the beginning of each four-week cycle of packs. Most people on the service had their medicines dispensed in a compliance pouch pack. These packs were assembled by an automated robot at the company's hub pharmacy. The pharmacy completed all administration tasks associated with this service. Individual records were in place for each person on the service. And these were checked against the prescriptions received to help identify changes to medication regimens. Changes were clearly recorded. A pharmacist completed a clinical check of the prescription and patient record before the pharmacy sent a copy of the record to the hub dispensary. The pharmacy also sent stock to fill the pouches to the hub dispensary. At the hub dispensary a pharmacy technician inputted the information into the robot and an accuracy checking technician accuracy checked the pouches. This process was supported by audit trails. The pouches contained details of each medicine inside. Once the assembled pouch pack was received back to the pharmacy a member of the dispensing team applied dispensing labels to the pack and initialled these. The RP then provided a check of the dispensing labels against the prescription and patient record. And signed to confirm this process had been completed. The RP explained he usually removed the first day's pouches and re-inserted them as part of this final label check. The packs were not supplied with PILs. A dispenser explained this had been fed back to the hub. And explained the hub should stamp each pack to confirm these were available upon request. But some assembled packs did not contain this information. This meant that there was a risk people may not receive all relevant information associated with their medicines.

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. Pharmacy team members identified how they applied 'mixed brand' labels if they could not supply the full quantity of a medicine as a single brand. This provided people with clear information about the medicines they were supplied with.

The pharmacy sourced medicines from licensed wholesalers and specials manufacturers. It had a scanning system to support it in complying with the requirements of the Falsified Medicine Directive (FMD). And the pharmacy was registered with SecurMed. A dispenser demonstrated how the system worked. And explained that team members had recently been encouraged to report any concerns with packs not scanning. This was to help identify and feedback improvements required. Pharmacy team

members had completed training associated with FMD and they had information available in supporting them in using the scanning equipment. They physically crossed through the unique barcodes on split packs before returning these to the shelves. The dispenser explained this negated the risk of a team member attempting to scan the same product twice. The pharmacy's SOPs had yet to be updated to reflect some changes to processes caused by FMD.

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. Some medicines had been repackaged to facilitate dispensing regularly prescribed pack sizes. For example, some packs of 112 paracetamol 500mg tablets had been created ready for dispensing. The pharmacy team members identified how expiry dates and batch number of medicines going into other packets were checked to ensure they matched. Medicines packaged in white boxes contained full information of the products inside on the label. And patient information leaflets were seen to be stored with the medicine inside each box.

The pharmacy team followed a date checking rota to help manage stock and it recorded details of the date checks it completed. Checks had fallen a little behind on the three-monthly rota. Short-dated medicines were generally identified and the team annotated details of opening dates on bottles of liquid medicines. An amber bottle containing alginate raft forming oral suspension did not have full details of the information inside the bottle, such as batch number and expiry date. And during random checks of dispensary stock a Glandosane oral spray was found to have expired in November 2019. Both medicines were removed and brought to the direct attention of the RP. No other out-of-date medicines were found during checks of dispensary stock. And pharmacy team members were observed checking expiry dates during the dispensing process. Medical waste bins, sharps bins and CD denaturing kits were available to support the team in managing pharmaceutical waste.

The pharmacy received details of medicine recalls and drug alerts electronically. And it kept an electronic audit trail of action taken in response to alerts. There were some Emerade autopens within the consultation room to support the vaccination services. The RP explained that after reviewing details of a recent recall of all unexpired stock of Emerade due to a risk of an autopen failing to activate. He had made the decision that the pens were not for onward supply. And he had assured himself that he had enough back-up autopens and adrenaline ampoules available to treat an anaphylactic reaction if an autopen did fail to activate.

The pharmacy held CDs in a secure cabinet. Medicine storage inside the cabinets was orderly. There was designated space for storing patient returned, and out-of-date CDs. The pharmacy stored assembled CDs in clear bags with prescription forms attached. This helped prompt additional checks prior to the medicine being handed out. The pharmacy had a large medical fridge. Medicines inside were well organised. It used clear bags for storing assembled insulin products. And the RP explained how this prompted additional checks prior to handout. The pharmacy team used a data tracker to monitor fridge temperatures. And it could download temperature mapping from the data device in the event there was a concern about how the fridge was operating.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs for providing its services. It monitors its equipment to help provide assurance that it is in safe working order. Pharmacy team members manage and use equipment in a way which protects 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 could access additional resources through the internet. The pharmacy's computer system was password protected. And information on computer monitors was protected from unauthorised view through the layout of the premises. Pharmacy team members on duty had working NHS smart cards. The pharmacy stored assembled bags of medicines on allocated shelving within the dispensary. Details on bag labels and prescription forms could not be read from the public area of the pharmacy. Pharmacy team members used cordless telephone handsets. This meant they could move out of ear-shot of the public area when having confidential telephone conversations.

Crown stamped measuring cylinders were in place for measuring liquid medicines, including separate cylinders for use solely with methadone. The pharmacy had clean counting equipment for tablets and capsules. A separate triangle for use when counting cytotoxic medicines was available. The pharmacy had a range of equipment to support pharmacists in completing consultations with people. This equipment was stored neatly in the consultation room. And it included a blood pressure machine and glucometer. The RP confirmed the equipment was replaced periodically. The glucometer was used for screening purposes only. And the RP confirmed people would be signposted onto their GP if the results indicated the need for further investigation. Stickers on the pharmacy's electrical equipment indicated portable appliance checks had last been completed in January 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.