General Pharmaceutical Council

# Registered pharmacy inspection report

**Pharmacy Name:** Weldricks Pharmacy, The Hopwood Centre, Chestnut Avenue, Carcroft, Doncaster, South Yorkshire, DN6 8AG

**Pharmacy reference:** 9011203

**Type of pharmacy:** Community

**Date of inspection:** 23/01/2020

## Pharmacy context

This is a community pharmacy in a village approximately six miles from Doncaster in South Yorkshire. The pharmacy relocated from former premises to its new location in the summer of 2019. 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 some people with their medicines in multi-compartment compliance packs, designed to them to remember to take their medicines. And it provides a medicine delivery service 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 | 2.5 | Good practice | The pharmacy shows how it both promotes and responds to feedback from its team members by using their ideas to inform service delivery. |
| **3. Premises** | Standards met | N/A | N/A | N/A |
| **4. Services, including medicines management** | Standards met | 4.1 | Good practice | Pharmacy team members promote innovative ways of accessing some of the pharmacy's services, using a smart phone application. This means people can contact the pharmacy team when it is convenient to them, without having to attend the pharmacy or pick up the telephone. |
| | | 4.2 | Good practice | Pharmacy team members recognise the benefits of the services they provide. They are particularly good at supporting people in taking higher risk medicines safely. They do this by completing and recording therapy monitoring checks each time they dispense these types of medicine. |
| **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 advertises how people can provide feedback about its services. And it responds appropriately to the feedback it receives. It keeps all records required by law up to date. And it manages peoples private information with care. Pharmacy team members act openly and honestly by sharing information when mistakes happen. And they engage in some shared learning processes to help reduce identified risks. They understand their role in helping safeguard the safety and wellbeing of vulnerable people.

### Inspector's evidence

The pharmacy had a set of up-to-date standard operating procedures (SOPs). It held its SOPs electronically on 'Pharmapod'. The SOPs had been reviewed in Autumn 2019 following the appointment of a new superintendent pharmacist. They covered responsible pharmacist (RP) requirements, controlled drug (CD) management, dispensary processes and services. The recent review had considered changes in dispensing processes following the introduction of the Falsified Medicines Directive (FMD). A member of the superintendent's team had prepared the SOPs. But there was no indication of the superintendent pharmacist authorising them. Pharmacy team members demonstrated a memo which had been received from the superintendent pharmacist. The memo included details of the review which had taken place.

The SOPs set out the roles and responsibilities of staff. And training records for all but one member of the team confirmed that team members had read and understood SOPs relevant to their roles. The team member with no training record was aware of the anomaly and explained she had completed learning associated with the SOPs. And was observed working in accordance with SOPs throughout the inspection. A member of the team explained what tasks could and couldn't be completed if the RP took absence from the premises. And an accuracy checking technician (ACT) explained details of her role. Pharmacists physically marked prescriptions to identify they had clinically checked them. And the ACT explained how she would refer to a pharmacist if she was at all concerned with a prescription. The ACT maintained a checking portfolio to support the revalidation of her checking qualification.

Workflow in the dispensary was organised. Work benches were clear of clutter and workload was effectively managed. Labelling, assembly and accuracy checks took place in separate areas of the dispensary. Acute work was managed at the front of the dispensary and work benches at the back of the dispensary were used to process much of the managed workload. Tasks associated with the multi-compartment compliance pack service were completed at the back of the dispensary. This provided a relatively distraction free environment for assembling packs.

Pharmacy team members discussed the near misses they made with the pharmacist or ACT. The pharmacist or ACT had then been entering details of the near miss on their own record. The pharmacy had recently changed this process to encourage self-reporting from its team members. And a dispenser discussed the benefits of making her own record as it had provided her with more time to reflect on the contributory factors of the near miss and ways to minimise the risk of a similar mistake occurring. The ACT had very recently taken over as the pharmacy's clinical governance lead. She had attended a learning event at the pharmacy's head office to support her new role. The role of the clinical

governance lead included reviewing near misses and incidents on a regular basis. There was some evidence of trend analysis reviews and learning outcomes from team meetings. But these were not recent. Any records made of clinical governance meetings over the past few months could not be found. Pharmacy team members demonstrated actions taken to reduce risk. For example, by engaging in learning associated with 'look-alike and sound-alike' medicines and by separating these medicines on the dispensary shelves.

The pharmacy reported its dispensing incidents electronically through Pharmapod. These were reviewed by the area manager and any additional actions required were highlighted within reports. The pharmacy had not had any reported incidents since moving premises. But reports from the previous premises were available. These reports were thorough and contained a risk assessment of the incident and learning outcomes. The records were updated regularly once these learning outcomes had been applied.

The pharmacy had a complaints procedure. And it provided details of how people could leave feedback or raise a concern about the pharmacy through its practice leaflet. It also promoted how people could leave feedback through the internet. The pharmacy team regularly checked www.nhs.uk to review any feedback it received. And the superintendent pharmacist had sent a memo of thanks to the team following a very positive review relating to the flu vaccination service. A pharmacy team member explained how she would manage a concern. And provided an example of how she had responded when a person had been unhappy. Pharmacy team members were aware of how to provide people with details of the company's complaints manager should a person wish to escalate their concern further.

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 pharmacy held its CD register electronically. A sample of the register examined was compliant with legal requirements. The pharmacy maintained running balances in the register. And full balance checks generally took place at monthly intervals. Physical balance checks of several morphine preparations complied with the balances 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 were returns dating back several months waiting to be destroyed. The pharmacy kept records for private prescriptions and emergency supplies within an electronic Prescription Only Medicine (POM) register. It printed its POM register at regular intervals and matched entries against the private prescriptions it had dispensed. Record examined complied with legal requirements. A sample of the pharmacy's specials records conformed to the requirements of the Medicine & Healthcare products Regulatory Agency (MHRA).

The pharmacy displayed a privacy notice and information about how the pharmacy used people's information was available within its practice leaflet. All pharmacy team members had completed mandatory information governance training. The pharmacy had completed an internal information governance audit in March 2019. And it had submitted its annual NHS Data Security and Protection toolkit as required. The front work benches of the dispensary were protected by a part-partition wall. Pharmacy team members demonstrated how they applied vigilance when managing information on these work benches. And they had fed back some concerns about the open-plan style of working. In response to these concerns some frosted covering had been arranged. This was due to be fitted to the clear windows at the top of the part-partition wall to reduce the risk of any accidental breach in confidentiality. The pharmacy disposed of confidential waste through securing it in white sacks. These were collected by a company delivery driver and stored securely at the pharmacy's head office until destruction took place.

The pharmacy had procedures and information relating to safeguarding vulnerable people in place. Pharmacy team members had completed e-learning on the subject and all pharmacy professionals had completed level two safeguarding training. Pharmacy team members could explain how they would recognise and report a safeguarding concern. The RP reflected on a serious concern she had reported whilst working in a relief role for the company. She had sought both peer support and support from her area manager when reporting the concern. Other examples of concerns reported by the team were discussed.

## Principle 2 - Staffing ✔ Standards met

### Summary findings

The pharmacy has enough skilled and knowledgeable people working to provide its services safely. It supports the learning needs of its team members through ongoing training and structured feedback. And it shows how it both promotes and responds to feedback from its team members by using their ideas to inform service delivery. Pharmacy team members support each other well. And they share learning by engaging in regular conversations relating to risk management and safety.

### Inspector's evidence

On duty at the time of inspection was the RP (pharmacy manager), an ACT and three qualified dispensers, one of which was the pharmacy's supervisor. A member of the superintendent's team was also present throughout the inspection. The pharmacy employed another qualified dispenser and a medicine counter assistant. Company employed drivers provided the medication delivery service. The RP explained the pharmacy had suffered from some acute staffing issues since opening. This was due to two team members leaving and some unplanned leave within the team. The pharmacy had been able to access support from the company's relief team during this time. And staffing numbers and skill mix had stabilised within the last month.

The pharmacy's supervisor supported the RP in ensuring learning was up to date and news letters and memos were read and signed by individual team members. Pharmacy team members could take some learning time during working hours. But the opportunity to do this had lessened during the recent staffing situation. And some team members reported completing regular e-learning through MediaPharm at home. All pharmacy team members engaged in a structured appraisal process which involved a one-to-one meeting with either the supervisor or manager.

The pharmacy team members were observed greeting people by name and engaged well in conversation with people about their health and wellbeing. They worked well together. For example, the ACT was observed supporting a newer member of the team with an IT related task during the inspection. The RP was generally positive when discussing how the pharmacy team used targets for services such as Medicines Use Reviews (MURs) and New Medicine Service (NMS) as a support tool for delivering services. And she confirmed she felt well supported by pharmacy team members when delivering these services.

Pharmacy team members updated each other about daily tasks and workload management through informal conversations. For example, the RP was observed updating the team about a Serious Shortage Protocol (SSP) which had been withdrawn. This prompted team members to contact the surgery to discuss a matter as the pharmacy was unable to obtain a medicine it had received a prescription for. The team members met a few times each month to discuss patient safety events and important information. But they did not always record the outcomes of these discussions. This meant there was a risk that some information or shared learning opportunities could be missed, if all staff weren't present when a meeting took place.

The pharmacy had a whistleblowing policy in place. And pharmacy team members were clearly confident when explaining how they could raise a concern at work. They also understood how to

escalate a concern if required. They expressed that they felt supported at work and were confident in providing feedback. One member of the team had provided feedback after working at another pharmacy owned by the company in regard to improving the process for finding assembled bags of medication in the retrieval area. The team had implemented the process which was working well. There was also good evidence of peer support. For example, a team member had been struggling with managing administration tasks associated with the pharmacy's repeat prescription service. The team had brainstormed better ways of working and after some suggestions a new alphabetised system was put into place. The system appeared to be working well for all team members.

## Principle 3 - Premises ✔ Standards met

### Summary findings

The pharmacy is clean and secure. It provides a modern and professional environment for the delivery of healthcare services. 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 well maintained and it was secure. Pharmacy team members could report maintenance issues directly to the company's maintenance team through an application. And they reported that matters were dealt with swiftly. There were no outstanding maintenance issues reported at the time of inspection. The pharmacy was clean. Floor spaces and workbenches were free from clutter. Antibacterial handwash and towels were available at designated handwashing sinks. It was air-conditioned. And lighting throughout the premises was bright.

The public area was open plan and accessible to people using wheelchairs and pushchairs. It provided seating for people waiting for prescriptions or a service. There was a clearly sign-posted consultation room. The room was a good size and it was professional in appearance. A second private consultation space provided access to a hatch leading into the dispensary. This provided additional privacy to people attending the pharmacy for services such as supervised consumption.

The dispensary was a good size for the level of activity undertaken. And pharmacy team members had settled into the new premises well. The ACT discussed adaptions she had made to her working processes to help increase her concentration due to the layout of the new premises. An area of the dispensary was out of direct line of sight from the public area. This area was used to complete administration tasks and wholesaling activity. It also provided access to the hatch leading to the second private consultation area. To the side of the dispensary was staff break facilities.

## Principle 4 - Services ✔ Standards met

### Summary findings

The pharmacy's services are accessible to people. And its team members promote innovative ways of accessing some of these services. This means people can contact the pharmacy team when it is convenient to them, without having to attend the pharmacy or pick up the telephone. The pharmacy has procedures to support its team members in delivering services safely and effectively. And pharmacy team members recognise the benefits of the services they provide. They are particularly good at supporting people in taking higher risk medicines safely. They do this by completing and recording monitoring therapy checks each time they dispense these types of medicine. The pharmacy has records and systems in place to make sure people get the right medicines at the right time. It obtains its medicines from reputable sources. And it manages them appropriately to help make sure they are safe to use.

### Inspector's evidence

People accessed the pharmacy through a push/pull door at street level. A doorbell was available for use by people requiring assistance with access. The pharmacy advertised its opening hours and details of its services. A health promotion display on the part-partition wall between the public area and dispensary was prominent. And members of the team could provide examples of how people visited the pharmacy to speak with team members about their health and wellbeing. Pharmacy team members were aware of how to signpost people to another pharmacy or healthcare provider if they were unable to provide a service.

Pharmacy team members were responsive to people's needs. During the inspection several people were observed asking to speak with the pharmacist by name. And the RP took time to discuss their health concerns with them. The supervisor acted to support a person who required some assistance with a dressing. And the ACT was observed listening attentively to a person about a change in medication. She followed the conversation up by making appropriate checks with the surgery before passing the information onto the pharmacist.

The RP had access to up-to-date patient group directions (PGDs) to support the supply of emergency hormonal contraception and administration of flu vaccinations. The most recent version of the minor ailments protocol was also available for team members to refer to. The RP reflected on positive feedback received from services. This feedback ranged from the team managing an acute event when a person had taken ill in the pharmacy to positive interventions from MURs. The RP reflected on some outcomes from the MUR and NMS service. And explained how people seemed to appreciate the time taken to go through their medicines with them and answer any questions they had. For example, by advising on an appropriate time to take their medication.

Pharmacy team members actively promoted the company's smart phone application. This allowed people to re-order their prescriptions with the pharmacy. And set up reminders and alarms to support them in taking their medication. A member of the team demonstrated the communication function of the application. This allowed people to communicate directly with the pharmacy team. And team members responded to queries sent through the application in a timely manner. Examples of these messages included informing people when their medication was ready to collect and notifying people of

the need for them to book an appointment for a medication review with their GP. The application was popular across all age groups and the RP provided examples of the mixed demographic using the application.

The pharmacy had good systems for managing higher risk medicines such as opioids, warfarin, lithium and methotrexate. All team members were trained to identify these medicines and engage in ensuring appropriate monitoring checks were completed. The pharmacy highlighted prescriptions for CDs. This prompted additional checks throughout the dispensing process. The RP demonstrated opioid therapy check records. These indicated the team routinely referred prescriptions for fentanyl, morphine and oxycodone to the RP for an appropriate therapy check. This involved ensuring any dose increases were checked and confirmed with people. Pharmacy team members also recorded the checks associated with warfarin, lithium and methotrexate. The pharmacy was not regularly dispensing valproate to people in the high-risk group. But a pharmacy team member discussed the requirements of the valproate pregnancy prevention programme (PPP). And the pharmacy had high-risk warning cards ready to issue to people if required. It was engaging in medication safety audits associated with the NHS Pharmacy Quality Scheme (QPS).

The pharmacy used tubs and baskets throughout the dispensing process. This kept medicines with the correct prescription form. And it helped to identify workload priority. Pharmacy team members signed the 'dispensed by' and 'checked by' boxes on medicine labels to form a dispensing audit trail. They also completed relevant sections of an audit grid on prescription forms. The grid identified who had received the prescription, labelled it, assembled it and accuracy checked it. The pharmacy team kept original prescriptions for medicines owing to people. The prescription was used throughout the dispensing process when the medicine was later supplied.

The pharmacy had a robust audit trail associated with its managed repeat prescription collection service. A full audit trail of what prescriptions were ordered was maintained. This provided the pharmacy with the opportunity to chase any missing prescriptions and manage queries prior to a person requiring their medicine. The team had worked with the surgery to streamline the ordering process through a daily drop off and collection service. And the surgery wrote notes on the pharmacy's record sheet to help notify pharmacy team members of any messages to be passed to people. For example, the need to attend for a medication review. Pharmacy team members also highlighted this information on repeat prescription slips. People receiving their medicines through the pharmacy's delivery service were asked to sign for receipt of their medication.

Each person receiving their medicines in multi-compartment compliance packs had a profile sheet in place. And pharmacy team members recorded changes to medication regimens and informed the RP of changes. The profile sheets contained most details of the persons medication regimen, including whether the pharmacy or person was responsible for managing prescription orders associated with 'when required' medicines. But the sheets did not routinely contain the formulation of the medicine. A sample of assembled packs contained full dispensing audit trails. The pharmacy provided descriptions of medicines inside the packs to help people identify them. And it supplied patient information leaflets with packs at the beginning of each four-week cycle.

The pharmacy sourced medicines from licensed wholesalers and specials manufacturers. Pharmacy team members were knowledgeable about FMD. And could demonstrate how the pharmacy complied with FMD requirements when dispensing medicines in compliant packaging. It had set up a 'quarantine' basket in the event it identified medicines which could not be supplied. It had quarantined some dexamphetamine in its CD cabinet following an FMD alert stating the batch of medicine was out of date, despite the packaging stating otherwise. And it had taken appropriate action to contact its buying

department who had brought the alert to the manufacturers attention. The manufacturer had confirmed the medicine was genuine. Correspondence from the manufacturer was demonstrated.

The pharmacy stored Pharmacy (P) medicines in cabinets to the side of the healthcare counter. Appropriate signage was displayed indicating to people that assistance was required when selecting medicines from behind the Perspex screens. It stored medicines in the dispensary on shelves, in their original packaging and in an orderly manner. CDs were held securely in a CD cabinet. This was an appropriate size for the amount of stock held. And there was room for segregating out-of-date and patient returned CDs within the cabinet. It held its cold chain medicines in two fridges. Assembled cold chain medicines were held in clear bags. This prompted additional checks prior to the supply of these medicines. The fridges were fitted with thermometers and data trackers. Temperature records were generally maintained, one date in January was missing from a record. The records confirmed that both fridges were operating between two and eight degrees Celsius.

A date checking rota was in place. The last checks recorded were October 2019 and the RP acknowledged checks were due again. A random check of dispensary stock found an expired bottle of alimemazine tartrate syrup. It was highlighted to indicate it was short dated, as were other short-dated medicines. This was brought to the attention of the RP and removed from stock. Pharmacy team members annotated bottles of liquid medicines with the date of opening. This prompted checks to ensure the medicine remained safe and fit to supply to people.

The pharmacy had medical waste bins, sharps bins and CD denaturing kits available to support the team in managing pharmaceutical waste. It received details of medication recalls and drug alerts electronically. And the RP demonstrated how all alerts were actioned to date. The pharmacy printed copies of alerts and kept these for reference purposes.

## 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

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 and intranet access provided further reference resources. And the RP explained how information from www.nhs.uk was often printed and given to people who attended for further information about their medical condition. She explained how this approach helped people to absorb information following speaking with a member of the team.

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

The pharmacy had clean, crown stamped measuring cylinders for measuring liquid medicines. And these included separate cylinders for use with methadone. Counting equipment for tablets and capsules was available. The pharmacy held equipment to support the seasonal flu vaccination service in the consultation room. For example, adrenaline autopens and a sharps bin. Equipment to support an NHS health check service was also available in the consultation room. Stickers on electrical equipment confirmed it had been subject to visual safety checks in August 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. |