General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Allied Pharmacy Queensway, 22-24 Queensway, Gainsborough, Lincolnshire, DN21 1SN

Pharmacy reference: 9011724

Type of pharmacy: Community

Date of inspection: 18/09/2023

Pharmacy context

This community pharmacy is on a housing estate in Gainsborough, Lincolnshire. Its main services include dispensing NHS prescriptions and selling over-the-counter medicines. It also provides the NHS New Medicine Service (NMS), NHS blood pressure check service, substance misuse services, and flu and COVID vaccination services. It supplies some medicines in multi-compartment compliance packs, designed to help people remember to take their medicines. And it delivers medicines to people's home.

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	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 effectively. It keeps people's confidential information secure. And it generally keeps the records it must by law. Pharmacy team members understand how to recognise and respond to safeguarding concerns. They reflect on the feedback they receive from people using the pharmacy. And they share learning and act to reduce risk following the mistakes they make during the dispensing process.

Inspector's evidence

The pharmacy had very recently received a new set of standard operating procedures (SOPs). Not all team members had signed the previous version of SOPs. They had good knowledge of their roles and responsibilities and understood when to refer to a pharmacist for support. And they knew what tasks could not take place if the responsible pharmacist (RP) took absence from the premises. The pharmacy manager, who was a qualified dispenser, provided details of training arrangements to support all team members in ensuring they had read and understood the recently updated SOPs. The pharmacy had a current business continuity plan and team members knew who to contact in the event an emergency situation arose.

Pharmacy team members routinely recorded mistakes made and identified during the dispensing process, known as near misses. They received feedback following a near miss and entered details of the event into a near miss record in the dispensary. The team regularly discussed patterns in near misses. But it did not generally record the actions it had taken to reduce risk following these conversations to help measure their effectiveness. Team members explained the current focus was on reducing noise levels in the dispensary to help them to concentrate on their work. The RP explained how they would respond to a mistake that was identified following the supply of a medicine to a person, known as a dispensing error. This included speaking to the person affected, investigating, and correcting the mistake, and reporting the incident. The team submitted Incident reports electronically to the superintendent pharmacist (SI).

The pharmacy had a complaints procedure. But leaflets informing people how they could raise a concern or provide feedback about the pharmacy had been removed from the public area during the recent refit. These were reintroduced shortly after the inspection. Team members knew how to manage feedback and provided examples of how they shared learning following feedback to help improve people's experience. Team members engaged in learning relating to confidentiality and data security. The pharmacy held all personal identifiable information in the staff-only area of the premises. Confidential waste was separated from general waste and securely disposed of. The pharmacy advertised details of its privacy policy and of its chaperone policy within its private consultation space. Pharmacy team members had engaged in safeguarding learning to help protect vulnerable people. They knew how to recognise and escalate these types of concerns. And they understood what action to take if somebody presented at the pharmacy seeking support or using code words associated with safety initiatives designed to offer a safe space to people experiencing domestic violence.

The pharmacy had current indemnity insurance. The RP notice on display contained the correct details of the RP on duty. And the RP record was generally completed in full; occasional records did not have

the sign-out times of the RP. A sample of other pharmacy records examined mostly complied with legal requirements. On some occasions team members did not record both the date of prescribing and date of dispensing when making records of the private prescriptions the pharmacy dispensed. And the address of the wholesaler was not always recorded in the controlled drug (CD) register when receipt of a CD was entered. The pharmacy maintained running balances in the CD register and completed full balance checks of solid dose formulations of CDs weekly against the register. But stock checks of liquid dose formulations did not take place regularly. And this had made it more difficult for the team to investigate a recent discrepancy in the register. A random physical balance check of a CD carried out during the inspection complied with the running balance in the register. The team recorded patient-returned CDs in a separate register at the point of receipt.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has a team of people who work well together to provide its services. Pharmacy team members complete regular learning relevant to their role. And they engage in structured reviews designed to support their learning and development. Pharmacy team members take part in regular conversations about workload and safety in the pharmacy. And they know how to provide feedback at work.

Inspector's evidence

The pharmacy did not have a regular pharmacist. The RP on duty was a company-employed relief pharmacist with good working knowledge of the pharmacy's processes. They were supported by the pharmacy manager, a delivery driver, two trainee dispensers and a team member currently working through their induction period. The pharmacy employed another trainee dispenser, a nurse, another delivery driver, and a qualified dispenser. The team planned workload well to help manage planned leave. Most team members worked fulltime which meant there was not much flexibility within the team to provide support when unplanned leave occurred. The manager explained they could seek support from the SI if additional staffing was required due to an unplanned absence. Workload was up to date and team members engaged well with each other. For example, the manager was observed teaching a trainee dispenser the correct technique for measuring liquid medicines accurately.

Pharmacy team members engaged in ongoing learning relevant to their roles. This had recently included several team members completing vaccination training to support the pharmacy's flu and COVID vaccination services. Team members enrolled on accredited training courses received support with their learning. And they were able to complete some learning at work during quieter periods. Pharmacy team members engaged in an appraisal process, this included induction reviews designed to help support them in their learning and development. The manager provided details of targets the pharmacy had. And the RP discussed these and explained how they felt able to apply their professional judgement when providing pharmacy services. Pharmacy team members engaged in regular discussions about workload and patient safety. They knew how to provide feedback at work, and they understood how to raise and escalate concerns. They had recently had the opportunity to provide input into designs for the layout of the new dispensary.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean and secure. It provides a modern and professional environment for delivering its services. People using the pharmacy can speak with a member of the pharmacy team in a private consultation room.

Inspector's evidence

The pharmacy was secure and maintained to a good standard. The recent refit had modernised the fittings and had provided significantly more space. The pharmacy was clean and organised. Lighting was bright throughout the premises and air conditioning helped provide an ambient environment for delivering pharmacy services. Pharmacy team members had access to handwashing facilities including antibacterial hand wash and paper towels at sinks. The public area stocked health related items and toiletries. Two private consultation rooms led off the public area. The rooms were professional in appearance, they contained sinks and furnishings inside the rooms were easy to keep clean.

Pharmacy team members used the space in the dispensary well with separate areas for labelling, assembling, and checking medicines. There was protected space for completing higher-risk tasks such as assembling medicines in multi-compartment compliance packs. Team members had access to staff facilities off the dispensary and there was a small stock room at the back of the premises.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's services are readily accessible to people. It obtains its medicines from reputable sources. And it generally stores its medicines safely and securely. It carries out ongoing checks to ensure medicines are fit to supply to people. Team members provide relevant information when supplying medicines to help people take them safely. But they do not always follow the pharmacy's written procedures when providing medicines in multi-compartment compliance packs. So, they cannot be sure they always work in the safest and most effective way.

Inspector's evidence

People accessed the pharmacy from a small step up from street level. Team members were vigilant in responding to people requiring assistance with accessing the premises. The pharmacy advertised its opening hours and details of its services within window displays. There was ample room in the public area for people to stand whilst waiting for a service. One seat was provided in the public area. A team member explained that seating from one of the pharmacy's consultation rooms could be offered to a person if required. Team members knew how to signpost a person to another pharmacy or healthcare professional when the pharmacy was unable to provide a service or supply a medicine.

The pharmacy protected Pharmacy (P) medicines from self-selection by displaying them behind the medicine counter behind plastic screens in the public area of the pharmacy. The screens had clear guidance that support was needed from a team member in purchasing these medicines. The team was vigilant when managing repeat requests for higher-risk P medicines subject to abuse, misuse and overuse and were confident in managing these requests and provided evidence of recent monitoring. Team members understood the requirements of the valproate Pregnancy Prevention Programme (PPP). And there was some evidence of checks associated with the PPP being recorded on the patient medication record (PMR). Tools to support the safe supply of valproate to people were readily available. Team members used stickers to identify bags of assembled medicines containing higher-risk medicines. This prompted additional checks during the dispensing process, such as checks of the validity period of a prescription for a CD and referral to a pharmacist for counselling when required. But pharmacists did not generally record their counselling notes on the PMR to support continual care.

Information to support the delivery of the pharmacy's consultation services was readily available for team members to refer to. For example, current versions of the national protocols and patient group directions for delivering flu and COVID vaccinations. A nurse led on the pharmacy's clinical services, and these were accessible to people three days a week with walk-in appointments available. Two other team members were trained vaccinators and understood their role in providing the vaccination services through the national protocols. Pharmacy team members providing the needle exchange service had received appropriate training to ensure the service was provided safely, this included not handling any sharps waste directly. The team managed dispensing services efficiently with systems to identify acute prescriptions requiring priority. The pharmacy kept each person's prescription separate throughout the dispensing process by using baskets. The pharmacy retained prescriptions for owed medicines, and team members dispensed from the prescription when later supplying the owed medicine. It kept an audit trail of each person it delivered medicine to. Pharmacy team members signed the 'dispensed by' and 'checked by' boxes on medicine labels to form a dispensing audit trail.

The pharmacy used individual patient record sheets to support it in supplying medicines in multi-compartment compliance packs. Team members updated these sheets regularly, and they clearly recorded changes on a separate communication form kept with the record. The pharmacy provided patient information leaflets at the beginning of each four-week cycle of packs. And assembled packs contained full audit trails and clear descriptions of the medicines inside the compliance packs. But the backing sheets did not include adverse warnings about the medicines inside the compliance packs. The team acted swiftly to rectify this issue. On occasion the team assembled some compliance packs ahead of receiving a prescription. A team member explained this was done to help support workload when a member of the team was due to take leave. The process followed by team members considered the risks involved in this practice. Team members used up-to-date backing sheets to pick the medicines. The assembled pack was held with all relevant medicine packaging and the patient record sheet awaiting a final accuracy check. Once the pharmacy received the prescription each medicine was physically marked on it to identify a check against the patient record and prescription had been completed. The final accuracy check of these compliance packs was only carried out after the receipt of a prescription. But the pharmacy had not carried out a risk assessment of the process, and the practice was not in accordance with the pharmacy's dispensing SOPs. The pharmacy supplied some medicines to people residing in a local care home. It supplied these in original boxes with electronic medication administration records (eMARS) provided to the care home team to support it in the safe administration of medicines.

The pharmacy sourced medicines from licensed wholesalers and a licensed specials manufacturer. Medicine storage in the dispensary was orderly with most medicines stored in their original packaging. It stored a small number of medicines in amber bottles. These were labelled with the batch number and expiry date of the medicine inside the bottle. The pharmacy stored medicines subject to safe custody arrangements appropriately secure cabinets. Medicines inside the cabinets were stored in an orderly manner with out-of-date medicines clearly identified whilst waiting to be securely destroyed. The pharmacy stored medicines subject to cold chain requirements safely between two medical fridges. It maintained temperature records for one fridge, and this showed it was operating within the required temperature range. The second fridge had very recently been delivered and a temperature record had not been set up for this fridge. The manager confirmed the temperature had been checked each day to ensure it was operating at the correct temperature range. The maximum and minimum readings were within the required temperature range during the inspection. A temperature record was set up immediately to record the checks being made.

Team members generally annotated liquid medicines with details of the dates they had been opened. This prompted checks during the dispensing process to ensure the medicine remained safe to supply. The team completed regular date checking tasks and it recorded these. No out-of-date medicines were found during random checks of dispensary stock. But an open bottle of a liquid medicine was found to be annotated with only part of its opening date. The team acknowledged this was not enough information to identify how long it had been open for and appropriately disposed of the medicine. The pharmacy had medicine waste and sharps waste receptacles available to support the team in managing pharmaceutical waste. It received details of drug alerts and recalls by email, and it kept a record of the action it took in response to these alerts.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs for providing its services. It maintains its equipment appropriately. And its team members use the equipment and facilities in a way which protects people's confidentiality.

Inspector's evidence

Pharmacy team members had access to current reference resources. They had internet access and used password protected computers and NHS smartcards when accessing people's medication records. The pharmacy suitably protected information on computer monitors from unauthorised view. It stored bags of assembled medicines on designated shelving within the dispensary out of direct view of the public area. Team members used cordless telephones; this allowed them to hold phone conversations with people in private.

Pharmacy team members used standardised counting and measuring equipment when dispensing medicines. This included separate equipment for measuring higher-risk liquid medicines which mitigated any risk of cross contamination when dispensing these medicines. Equipment used to support the delivery of pharmacy services was from reputable manufacturers. It was stored neatly with information from the equipment manufacturer clearly accessible for team members to refer to when using the equipment. The nurse leading on the clinical services checked the equipment regularly. These checks included equipment used to treat an anaphylactic reaction. Team members reported regular health and safety checks of equipment and facilities taking place. For example, portable appliance checks of electrical equipment had been carried out in July 2023.

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.