General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Taffs Pharmacy, 72 Oswald Road, Scunthorpe, Lincolnshire, DN15 7PG

Pharmacy reference: 9012113

Type of pharmacy: Community

Date of inspection: 23/04/2024

Pharmacy context

This community pharmacy relocated from its previous premises to this new bespoke design premises around nine months ago. It is on a main road close to the centre of Scunthorpe, North Lincolnshire. Its main services include dispensing prescriptions and selling over-the-counter medicines. The pharmacy provides a good range of services including the NHS England Pharmacy First service, NHS blood pressure check service and vaccination services. It supplies some medicines in multi-compartment compliance packs, designed to help people remember to take their medicines. And it delivers some medicines to people's homes.

Overall inspection outcome

✔ **Standards met**

Required Action: None

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Summary of notable practice for each principle

Principle	Principle finding	Exception standard reference	Notable practice	Why
1. Governance	Standards met	N/A	N/A	N/A
2. Staff	Standards met	N/A	N/A	N/A
3. Premises	Standards met	3.1	Good practice	The pharmacy's bespoke design and use of good quality fittings provide a highly professional atmosphere for delivering healthcare services.
		3.3	Good practice	The pharmacy's fixtures and fittings support good hygiene practices. Its team members work effectively to ensure all areas of the extensive premises are frequently cleaned to a good 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 effectively identifies and manages the risks for providing its services. It has suitable processes to monitor risk and to support its team in responding to feedback it receives about its services. Overall, the pharmacy keeps its records as required by law. Pharmacy team members engage in shared learning following the mistakes they make during the dispensing process. They treat people's confidential information with care. And they have the knowledge and resources to support them in recognising and reporting concerns to help protect vulnerable people.

Inspector's evidence

The pharmacy used standard operating procedures (SOPs) to define its working practices. The superintendent pharmacist (SI) had implemented the current SOPs and personalised them for use in the pharmacy in October 2023. Team members accessed the SOPs electronically. And the pharmacy kept digital training records showing team members had read and understood the SOPs relevant to their roles and responsibilities. Team members were knowledgeable about their roles and demonstrated how they worked safely when completing tasks. They understood what tasks they could not complete if the responsible pharmacist (RP) took absence from the pharmacy.

The pharmacy used its patient medication record's (PMR) technology to help support the clinical checks of prescriptions. The SI provided details of the assurances they had gained prior to using this technology. Team members received training and the pharmacy completed a staged roll-out of the system's functions. The RP had the choice of enabling the technology when establishing the RP role. And took overall responsibility for the automated checks carried out. The RP on duty during the inspection was a regular locum pharmacist. They felt confident using the technology and demonstrated how it identified and highlighted information for the pharmacist to conduct further checks. The team used the PMR's barcode technology to support it in completing a series of safety checks during the assembly and accuracy checking process. The team demonstrated how the PMR flagged mistakes made during the dispensing process, known as near misses. The PMR did not produce dispensing labels until a team member rectified the mistake. Team members felt this supported them in working safely as it reduced the risk of human error during the dispensing process. The team referred any medicines that did not scan and any queries they had during the dispensing process to a pharmacist. Pharmacists routinely completed the final accuracy check of some medicines. These included controlled drugs (CDs) and medicines assembled in multi-compartment compliance packs.

The team kept a near miss record, and team members consistently reported these mistakes. They discussed their mistakes at the time an incident occurred. And they acted to reduce risk. For example, by sharing information when they noticed medicines in similar packaging to others. The layout of the dispensary supported safe dispensing practices. For example, the pharmacy held medicines dispensed frequently neatly in individually labelled tubs across one wall. This reduced the risk of a picking error occurring. The pharmacy had a process for reporting and learning from mistakes identified following the supply of a medicine, known as a dispensing incident. Incident reports were thorough and included an assessment of harm, contributory factors, and shared learning to reduce the risk of a similar mistake occurring.

The pharmacy had a complaints procedure. And it advertised how people could provide feedback or

raise a concern within its practice leaflet. Its team members knew how to respond to feedback and concerns from people. The team took care to investigate the feedback it received. And it provided information to people of the steps it took to investigate and resolve their concerns. It monitored improvement actions following feedback, such as recent changes it had made to its medicine delivery process. Pharmacy team members undertook learning to support them in identifying and reporting safeguarding concerns. They had access to information and contact details for local safeguarding teams. And they were familiar with what to do if a person presented at the pharmacy using code words publicised by national domestic violence safety initiatives, designed to support people in requesting access to a safe space.

The pharmacy held all personal identifiable information in the staff-only area of the premises and on password-protected computers. It separated its confidential waste from other waste, and it disposed of this securely. The pharmacy had current indemnity insurance. The RP notice had the correct details of the RP on duty and the notice was changed immediately when a new RP took over during the inspection. A sample of other pharmacy records including the RP record and specials records were completed as required. The pharmacy kept its private prescription register electronically, occasional entries in the register did not have the accurate date of prescribing recorded. The pharmacy kept its CD register electronically and in accordance with legal requirements. It maintained running balances in the register, and it completed frequent balance checks of physical stock against the register. Random physical balance checks of two CDs completed during the inspection matched the running balances in the register.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy employs a team of dedicated people with the appropriate skills and knowledge to provide its services safely. It has effective support processes to manage the number of team members in training roles and it monitors its staffing levels and skill mix appropriately. Pharmacy team members demonstrate enthusiasm for their roles. They engage in regular team discussions centred around managing workload and patient safety. And they feel empowered to provide feedback at work.

Inspector's evidence

The SI worked at the pharmacy full-time. Five trainee pharmacy technicians, an apprentice, a pharmacy student and two delivery drivers supported pharmacists in delivering the pharmacy's services. To support the training needs of team members the company employed a pharmacist with a background in pharmacy education as a training lead. The pharmacy also employed a nurse to support the delivery of its seasonal COVID vaccination clinic. And it employed regular locums to support it in providing pharmacy services, a locum pharmacist was acting as RP during the inspection and was working alongside the SI. Team members worked flexibly when required to support leave arrangements. And the SI discussed how they planned pharmacist cover according to staffing levels and services being delivered. The team was up to date with its workload and the working atmosphere was calm. A rota supported team members in completing daily tasks. This also helped to ensure team members were competent in completing a variety of different tasks to support the safe and effective running of the pharmacy.

Pharmacy team members received regular support and time for training. As well as day-to-day support from pharmacists, they received protected one-to-one learning time each month with the education lead to support their learning. They undertook meaningful learning to support the delivery of pharmacy services. For example, most team members had completed training to support them in taking people's blood pressures. And some team members had completed recent learning to support the implementation of a new ear care service. They worked well together and regularly shared information to support a consistent approach when delivering pharmacy services. The pharmacy was currently implementing a staff appraisal process. One team member had completed their appraisal to date. They had received appropriate time and preparation tools to prepare for the appraisal and reflect on their performance and development needs ahead of the appraisal taking place.

The pharmacy did not set any targets for its services. It monitored the delivery of its services by keeping a visual record of some of the services its team members provided. Team members explained this was to aid their confidence and development and to ensure they took opportunities to deliver services they had received training for. Pharmacy team members enthusiastically discussed their roles and demonstrated the tasks they undertook. They felt confident in providing feedback at work. And they understood how to raise a concern both internally within the company and externally if necessary.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy's bespoke design and high standard of fixtures and fittings provide a professional atmosphere for delivering pharmacy services. Team members keep the premises clean, and they use effective records to support good hygiene practices. People accessing the pharmacy's services are able to use a range of private consultation spaces when speaking to members of the pharmacy team.

Inspector's evidence

The premises were secure and in a good state of repair. The SI used local tradespeople to support in managing maintenance concerns. There were no outstanding maintenance issues reported. The standard of cleanliness throughout the pharmacy was good. Team members followed a cleaning rota and used a dedicated sluice room when disposing of wastewater after completing cleaning tasks. A high standard of fixtures and fittings throughout the premises contributed to the professional appearance of the pharmacy. Lighting was bright and air conditioning kept a comfortable ambient environment for delivering pharmacy services throughout the premises, including consultation rooms. Pharmacy team members had access to appropriate hand washing facilities. These facilities included consultation room sinks fitted with medical lever taps to support effective infection control measures.

The pharmacy was extensive and spread over two floors. The first floor provided team members with access to staff facilities and stock rooms. A room on this level was planned to be fitted out as a dedicated training space for team members to use. On the ground floor there was a large open plan public area. Half of this space was dedicated to providing a waiting area for people. People accessed two of the pharmacy's consultation rooms directly from the public area. A corridor leading from the main waiting area provided access to another five consultation rooms. A separate entrance was available to people accessing some of the pharmacy's services. This entrance led to a private consultation space with a hatch leading into the dispensary. The dispensary was a good size, and the layout was well thought out with different areas used to support individual workflows.

All consultation rooms were a good size and were fitted to a high standard, including covered power points fitted into the floors and cap and coved flooring to support the team in maintaining a hygienic environment for delivering clinical services. The consultation rooms were suitably protected from unauthorised access between use. One of the pharmacy's main consultation rooms faced the street and was fitted with a frosted window. But the level of frosting did not totally impair view of people using the room from the street. To assist with privacy, the pharmacy had put large vertical advertisement banners close to the window. The SI acknowledged the need to increase the level of frosting used on the window to prevent the risk of breaching a person's privacy when using the room.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's services are fully accessible to people. It obtains its medicines from reputable sources, and it generally stores and manages its medicines safely and securely. Pharmacy team members are confident in engaging with people visiting the pharmacy. They make effective records when providing pharmacy services. And they use the pharmacy's wide range of technology to support them in delivering pharmacy services safely.

Inspector's evidence

People accessed the pharmacy from a small ramp from street level. There was a range of informative information about the pharmacy's services displayed on a screen in its window. And a wide variety of information about health and social care services, chronic diseases and higher-risk medicines requiring ongoing monitoring were available to people in the public area of the pharmacy. Pharmacy team members knew how to signpost people to other healthcare providers and pharmacies should a person require a service or medicine the pharmacy could not provide.

The pharmacy was operating a COVID vaccination clinic. A registered nurse was administering the vaccinations and the pharmacists on duty understood their role in ensuring the service was provided safely when assuming RP responsibilities. The nurse had access to current patient group directions (PGDs) and appropriate equipment when providing this service. And the SI had assured themselves that the nurse had completed relevant learning to provide the service safely prior to them commencing their role. Pharmacists providing the NHS England Pharmacy First service had access to supportive information, including current PGDs, clinical pathways and the service specification to support the safe delivery of the service. The SI demonstrated the consultation process when providing the pharmacy's private services, these services included the supply of medicines through a PGD following a consultation with a pharmacist. The digital platform used to manage these services included access to PGDs and, a risk assessment of each service. Pharmacists used a guided consultation template to ensure consultations captured all relevant medical information to inform the safe supply of a medicine to a person. A sample of consultation records were completed with relevant information and clear rationale for supplying the medicines. The pharmacy was in the process of introducing other healthcare services, including an ear care service and preparation for the NHS Community Pharmacy Independent Prescribing Pathfinder Programme. The SI discussed the pharmacy's approach to identifying and managing risk when implementing new services.

The pharmacy protected Pharmacy (P) medicines from self-selection by displaying these behind its medicine counter. Pharmacy team members were confident in managing requests for P medicines liable to misuse and understood when to refer a request for a P medicine or advice to a pharmacist. The pharmacy team identified some higher-risk medicines during the dispensing process, such as CDs and cold chain medicines. This supported the team in applying additional checks during the dispensing and handout process. Pharmacy team members understood the requirements of the valproate Pregnancy Prevention Programme (PPP). They supplied all valproate in the manufacturers original box, and the RP discussed the counselling they would provide when supplying valproate to a person in the at-risk group. Pharmacists provided counselling on a range of higher-risk medicines when supplying them to people. But they did not generally record these types of interventions on people's PMR to support them in providing continual care. To support the safe supply of medicines to people following an opioid

treatment programme, team members transcribed information from prescriptions to the pharmacy's automated dispensing machine. The data accuracy of this information was checked by a pharmacist prior to supplies of medicines commencing. The pharmacy team had effective monitoring processes to identify missed doses of these medicines and it contacted the local substance misuse team when needed.

Team members used individual baskets to keep each person's prescription separate throughout the dispensing process. The pharmacy used technology to maintain effective audit trails when supplying medicines to people. The audit trails included identifying which team members participated in the dispensing process and tracked the delivery of medicines to people's homes. The pharmacy retained prescriptions for owed medicines, and team members dispensed from the prescription when later supplying the owed medicine. Pharmacy team members planned work for the supply of medicines in multi-compartment compliance packs well. They used the pharmacy's technology effectively to support them throughout the dispensing process. This included the use of a communication and planning application to track and record information, such as dose changes and communication received from surgery teams. A sample of assembled compliance packs contained clear information for people to support them in taking their medicines safely, including accurate descriptions of the medicines inside the compliance packs. But the pharmacy team did not always provide patient information leaflets to people receiving their compliance packs weekly.

The pharmacy sourced medicines from licensed wholesalers and specials manufacturers. It generally stored medicines in an orderly manner. Some medicines were found in stock which were not kept in their original packaging. The medicines were removed from stock and brought to the attention of the SI. Team members transferred some stock of a higher-risk liquid medicine to larger bottles for use with the pharmacy's automated dispensing machine. But they did not keep records of the batch number of the medicine and expiry dates of the medicine transferred to the larger bottles. This meant it was more difficult for the team to demonstrate how it safely monitored this process and to take appropriate action in the event a safety alert for the medicine was issued. The pharmacy held its CDs in legally compliant cabinets. And it held medicines requiring cold storage in medical fridges equipped with thermometers. It kept temperature records for the fridges which showed they were operating within the required range of two and eight degrees Celsius.

Pharmacy team members conducted regular checks of medicines. And they highlighted medicines with short expiry dates to prompt additional checks during the dispensing process. The pharmacy's PMR system also identified any expired medicines scanned during the dispensing process. Team members annotated bottles of liquid medicines with the date of opening. These checks and monitoring processes supported the team in ensuring medicines were safe to supply to people. A random check of dispensary stock found no out-of-date medicines. The team received medicine alerts electronically and kept a record of the checks it made in response to these alerts.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has appropriate equipment and facilities for providing its services. And its team members use the equipment in a way which protects people's privacy.

Inspector's evidence

Pharmacy team members had access to an appropriate range of digital reference resources to support it obtaining accurate information when providing services. For example, they accessed TravelHealthPro and the UKHSA Green Book when providing the travel vaccination services. They used passwords and NHS smart cards when accessing people's medication records. The pharmacy positioned its computer monitors appropriately to avoid the risk of sharing information displayed on them. The team stored bags of assembled medicines safely within the dispensary. This prevented people's personal information on bag labels and prescriptions from unauthorised view. The pharmacy had cordless telephone handsets. This allowed team members to walk out of earshot of the public area when discussing confidential information over the telephone.

The pharmacy had a wide range of equipment to support it in delivering its services. Equipment to support the delivery of consultation services was from recognised manufacturers and stored appropriately in the consultation rooms. And team members cleaned equipment appropriately between use. The SI reported that the pharmacy had acquired all equipment within its consultation room since relocating. But there was no indication of this, or of regular monitoring checks taking place to support the pharmacy team in demonstrating assurances that the equipment remained fit for purpose. Pharmacy team members used personal protective equipment, such as disposable gloves when handling medicines and performing some other tasks. The pharmacy had a range of appropriate clean counting triangles, capsule counters and CE marked measuring cylinders. The team used separate equipment when counting and measuring higher-risk medicines. The pharmacy had a service contract for its automated dispensing machine. The team completed calibration checks of the machine daily and followed daily cleaning schedules for the machine.

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.