General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Bethune Avenue Pharmacy, 75 Bethune Avenue, Anlaby Park Road South, HULL, North Humberside, HU4 7EH

Pharmacy reference: 1032059

Type of pharmacy: Community

Date of inspection: 06/02/2020

Pharmacy context

The pharmacy is in a suburb of Hull. The pharmacy dispenses NHS and private prescriptions. The pharmacy supplies some medicines in multi-compartment compliance packs to help people take their medicines. And it delivers medication to people's homes. The pharmacy provides the supervised methadone consumption service. The pharmacy provides the Community Pharmacist Consultation Service (CPCS). And the team offers free health checks such as blood pressure checks.

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	2.5	Good practice	The team members proactively identify opportunities to introduce new pharmacy services. And they work together and with other organisations to provide these services. The team members introduce processes to improve their efficiency and safety in the way they work.
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 team identifies and manages the risks associated with its services. People using the pharmacy can raise concerns and provide feedback. The team members have training and guidance to respond to safeguarding concerns. So, they can help protect the welfare of children and vulnerable adults. The pharmacy team members respond appropriately when errors happen. They discuss the errors and they take the action needed to help prevent similar errors happening again. But they don't fully record their errors. So, the team may miss opportunities to help identify patterns and reduce mistakes.

Inspector's evidence

The pharmacy had a range of up-to-date standard operating procedures (SOPs). These provided the team with information to perform tasks supporting the delivery of services. The SOPs covered areas such as dispensing prescriptions and controlled drugs (CDs) management. Each SOP listed the roles within the team the SOP was relevant to. Most team members had read the SOPs. And they had signed the SOPs signature sheets to show they understood and would follow the SOPs. A dispenser who had recently returned to the pharmacy after an absence had not signed the SOPs. The team members had a clear understanding of their role and worked within the scope of their role. The team referred queries from people to the pharmacist when necessary. The pharmacy had up-to-date indemnity insurance.

On most occasions the pharmacist when checking prescriptions and spotting an error asked the team member involved to find and correct the error. The pharmacy kept records of these near miss errors. And the team members recorded their own errors. A sample of the error records looked at found that the team members did not record details of what had been prescribed and dispensed to spot patterns. And they did not record what caused the error. The record showed the actions the team member had taken to prevent the error happening again. But most records had the same details such as double checking the medicine dispensed or re-dispensing the medicine. So, there was little evidence of individual reflection on the error and how to prevent the same error from happening again. The pharmacy technician transferred the information from the near miss log to the computer system to share with head office. The pharmacy team reviewed the near miss error records to spot patterns and make changes to processes. But it did not keep records of these reviews. The team members identified that they sometimes picked the warfarin 0.5mg strength instead of the 5mg strength. So, they moved the 0.5mg strength to a different section of the dispensary. The pharmacy team recorded dispensing incidents electronically. And sent the report to head office. These were errors identified after the person had received their medicines. A sample of dispensing incident reports looked at found the cause of the error was captured but the report did not capture the team's learning points and actions they had taken to prevent the error happening again.

The pharmacy completed an annual patient safety report. The report for 2019 stated the team were reminded to always check the medicine selected when dispensing against the prescription. And to be aware of medicines that looked alike and sounded alike (LASA). The team had separated LASA medicines such as sildenafil and sertraline. And team members highlighted to each other medicines with similar packaging when putting stock away. The report stated that several near miss errors happened after team members returned from their lunch break. So, the team members were advised to be extra careful when dispensing after having a break to ensure they were focused on the task. The

pharmacy had a procedure for handling complaints raised by people using the pharmacy. And it had a poster and leaflet providing people with information on how to raise a concern. The pharmacy team used surveys to find out what people thought about the pharmacy. The pharmacy published these on the NHS.uk website.

A sample of controlled drugs (CD) registers looked at found that they met legal requirements. The pharmacy regularly checked CD stock against the balance in the register. This helped to spot errors such as missed entries. The pharmacy recorded CDs returned by people. A sample of Responsible Pharmacist (RP) records looked at found that several entries did not have the time the pharmacist stopped being the RP. The team members knew what activities could and could not take place in the absence of the RP. Records of private prescription supplies and emergency supply requests met legal requirements. A sample of records for the receipt and supply of unlicensed products looked at found that they met the requirements of the Medicines and Healthcare products Regulatory Agency (MHRA).

The team had not received training on the General Data Protection Regulations (GDPR). But team members knew how to handle confidential information. The pharmacy technician who organised the training for the team accessed the online training modules during the inspection and found a GDPR module. The pharmacy had information for people to read on the confidential data kept and how it complied with legal requirements. And it displayed a GDPR privacy notice. The team separated confidential waste for shredding onsite. The pharmacy had a safeguarding policy and safeguarding guidance for the team to refer to. The regular locum pharmacist and pharmacy technician had completed level 2 training in 2019 from the Centre for Pharmacy Postgraduate Education (CPPE) on protecting children and vulnerable adults. The team had completed Dementia Friends training in 2019.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has a team with the qualifications and skills to support the pharmacy's services. The pharmacy provides team members with opportunities to develop their knowledge. And it gives team members some feedback on their performance. So, they can keep their skills and knowledge up-to-date. The team members support each other in their day-to-day work. They proactively identify opportunities to introduce new pharmacy services. And they work together and with other organisations to provide these services. The team members introduce processes to improve their efficiency and safety in the way they work.

Inspector's evidence

A part-time pharmacist covered some of the opening hours. And locum pharmacists covered the remaining opening hours. The pharmacy team consisted of a full-time pharmacy pre-registration student, a part-time pharmacy technician who was training to be an accuracy checking technician (ACT), a full-time dispenser who was also the pharmacy manager, four part-time qualified dispensers, and a delivery driver. The pharmacy displayed the team's training certificates for people using the pharmacy to see. At the time of the inspection a locum pharmacist, the pharmacy manager, the pharmacy pre-registration student, the trainee ACT, and two dispensers were on duty.

The pharmacy pre-registration student followed a structured programme and had also set personal objectives. The student wanted to focus on developing their skills and knowledge of selling over-the-counter medicines. And giving people advice on health matters. The team supported the student by referring queries from people to the student. The trainee ACT was actively involved in local pharmacy groups. And attended meetings to learn about services the pharmacy could provide. The trainee ACT was the community pharmacy lead within the local primacy care network (PCN) and represented five local pharmacies. The pharmacy technician had organised the blood pressure checking service with support from the British Heart Foundation.

The pharmacy provided extra training through e-learning modules. The trainee ACT organised the training for the team. The trainee ACT identified topics the team would find helpful and informed the team when the training modules were available. The team members had protected time to complete the training. The pharmacy provided regular team meetings. The pharmacy manager used the meetings to share information from head office with the team. And any other matters the team needed to be aware of. The team used a large board in the dispensary to communicate key pieces of information with each other. The pharmacy manager asked the team members to read the board each day so they were kept up-to-date. And to see what tasks they had to complete. The information on the board included a reminder for the team to use the person's electronic medication record (PMR) to capture all information received about the person. And that all emergency supply requests should be recorded.

The company did not provide performance reviews for the team. The pharmacy manager felt performance reviews were helpful for supporting and developing the team. So, had recently introduced performance reviews to give the team chance to receive feedback and discuss development needs. The team members received informal feedback and they celebrated success. For example, the team acknowledged the work the pharmacy technician was doing to increase the number of services provided by the pharmacy.

Team members could suggest changes to processes or new ideas of working. The team identified the importance of getting the deliveries ready before the driver arrived. So, had introduced a process to ensure the deliveries were ready. Each morning one team member organised the day's deliveries and printed off the delivery sheet. So, the delivery sheet was ready for when the driver arrived. And all medicines due to be delivered that day were in the delivery box. The pharmacy manager created a box for the team to hold CD prescriptions after the person had received their CD and a record had been made in the CD register. This helped the team locate the CD prescription if queries arose. The pharmacy did not have targets for its services. The team offered the services when they would benefit people.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean, secure and suitable for the services provided. And it has good facilities to meet the needs of people requiring privacy when using the pharmacy services.

Inspector's evidence

The pharmacy premises had been refitted which resulted in an extension to the dispensary. This provided the team members with more dispensing areas and storage space to manage the increase in their workload. The pharmacy was clean, tidy and hygienic. It had separate sinks for the preparation of medicines and hand washing. The consultation room contained a sink and alcohol gel for hand cleansing. The team kept floor spaces clear to reduce the risk of trip hazards.

The pharmacy had a large, sound proof consultation room. The team used this for private conversations with people. The premises were secure. The pharmacy had restricted access to the dispensary during the opening hours. The window displays detailed the opening times and the services offered. The pharmacy had a defined professional area. And items for sale in this area were healthcare related.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy team members provide services that support people's health needs. And they manage the pharmacy services well. The team members check for issues that could affect the safe and effective delivery of services. And they proactively act to address any they find. The pharmacy team members keep records of prescription requests and deliveries. So, they can effectively deal with any queries. The pharmacy obtains its medicines from reputable sources. And it stores and manages medicine well.

Inspector's evidence

People accessed the pharmacy via a step free entrance. The pharmacy had an information leaflet that provided people with details of the services it offered and the contact details of the pharmacy. The team had access to the internet to direct people to other healthcare services. The pharmacy kept a small range of healthcare information leaflets for people to read or take away. The service providing blood pressure (BP) checks was popular. The team focused on people who were not already diagnosed with high blood pressure and prescribed medicines. As they would be monitored. If the blood pressure reading was high the team gave the person a BP machine to use at home for them to take regular readings. The person presented the readings to the pharmacist who checked the results. And referred the person to their GP when required. Several people had been referred to the GP and were prescribed appropriate medicines. The team promoted the service to people attending the pharmacy. And some team members had held sessions with local groups. The pharmacy was part of a scheme to help reduce the number of unwanted medicines known as the point of dispensing intervention service (PODIS).

The pharmacy provided multi-compartment compliance packs to help around 50 people take their medicines. People received monthly or weekly supplies depending on their needs. To manage the workload the team divided the preparation of the packs across the month. The team usually ordered prescriptions one week before supply. This allowed time to deal with issues such as missing items. And the dispensing of the medication in to the packs. Each person had a record listing their current medication and dose times. The team checked received prescriptions against the list and queried any changes with the GP team. The team usually recorded the descriptions of the products within the packs. And it supplied the manufacturer’s patient information leaflets. The pharmacist bagged the packs after checking them. The team stored the completed packs on shelves labelled with the person’s name and address. The pharmacy received copies of hospital discharge summaries. The team checked the discharge summary for changes or new items. And liaised with the GP teams to request new prescriptions when required.

The pharmacy provided the multi-compartment compliance packs to two care homes. Each care home had around 40 rooms. The pharmacy technician managed the service with support from others in the team. The care homes teams ordered the prescriptions on week two of the monthly cycle. And sent a list of each person’s medicine to the pharmacy team. This indicated the medicines ordered, medicines not ordered but the person was still taking and any discontinued medicines. The pharmacy team sent the packs and medicines not included in the packs one week before the next cycle. This allowed time for the care home team to check the supply and chase up missing medicines. The team kept a list of medicines sent to the care home. The team recorded the colour of the pack the medicines were dispensed in. And it recorded those medicines supplied in separate bags. So, the pharmacy team could deal with queries from the care home teams such as missing medicines. The pharmacy technician

provided training to new members of the care home team. The training included how to book in the medicines sent from the pharmacy.

The pharmacy supplied methadone as supervised and unsupervised doses. And it prepared the methadone doses in advance before supply. This reduced the workload pressure of dispensing at the time of supply. The pharmacy stored the prepared doses in the controlled drugs cabinet with the prescription attached to the dose due that day. The team members provided a repeat prescription ordering service. The team usually ordered the prescriptions a week before supply. This gave time to chase up missing prescriptions, order stock and dispense the prescription. The team members kept the repeat prescription slips in a box in the date they were due to be ordered. The team members kept a record of the request. So, they could track the requests to identify missing prescriptions and chase them up with the GP teams. The team passed on information to people from their GP such as the need to attend the surgery for a medication review. The pharmacy team had completed checks to identify patients that met the criteria of the valproate Pregnancy Prevention Programme (PPP). And found one person who met the criteria but was not on a PPP. The regular pharmacist spoke to the person and found out why they were not on a PPP. And provided the person with the PPP information.

The pharmacy provided separate areas for labelling, dispensing and checking of prescriptions. The pharmacy team used baskets when dispensing to hold stock, prescriptions and dispensing labels. This prevented the loss of items and stock for one prescription mixing with another. The team members referred to the prescription when selecting medication from the storage shelves. The team members used this as a prompt to check what they had picked. The pharmacy used CD and fridge stickers on bags and prescriptions to remind the team when handing over medication to include these items. The pharmacy had a system to prompt the team to check that supplies of CD prescriptions were within the 28-day legal limit. The pharmacy had checked by and dispensed by boxes on dispensing labels. These recorded who in the team had dispensed and checked the prescription. A sample looked at found that the team completed the boxes. When the pharmacy didn't have enough stock of someone's medicine, it provided a printed slip detailing the owed item. And kept a separate one with the original prescription to refer to when dispensing and checking the remaining quantity. The pharmacy kept a record of the delivery of medicines to people. This included a signature from the person receiving the medication. The team checked the section holding completed prescriptions awaiting collection each month. And sent letters to people advising them that they had uncollected medicines.

The pharmacy team checked the expiry dates on stock. And kept a record of this. The last date check was on 23 January 2020. The team marked medicines with a short expiry date. No out-of-date stock was found. The team members recorded the date of opening on liquids. This meant they could identify products with a short shelf life once opened. And check they were safe to supply. For example, an opened bottle of Oramorph oral solution with 90 days use once opened had a date of opening of 23 November 2019 recorded. The team recorded fridge temperatures each day. A sample looked at found they were within the correct range. The pharmacy had medicinal waste bins to store out-of-date stock and patient returned medication. And it stored out-of-date and patient returned controlled drugs (CDs) separate from in-date stock in a CD cabinet that met legal requirements. The team used appropriate denaturing kits to destroy CDs.

The pharmacy had procedures and a computer software upgrade to meet the requirements of the Falsified Medicines Directive (FMD). The team had received FMD training. But the pharmacy did not have scanning equipment for the team members to scan FMD compliant packs. The team did not know when the equipment would be available. The pharmacy obtained medication from several reputable sources. And received alerts about medicines and medical devices from the Medicines and Healthcare products Regulatory Agency (MHRA) via email. The team printed off the alert, actioned it and kept a record.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide safe services and to protect people's private information.

Inspector's evidence

The pharmacy had references sources and access to the internet to provide the team with up-to-date clinical information. The pharmacy used a range of CE equipment to accurately measure liquid medication. And used separate, marked measures for methadone. The pharmacy had a fridge to store medicines kept at these temperatures. The pharmacy completed safety checks on the electrical equipment.

The computers were password protected and access to people's records restricted by the NHS smart card system. The pharmacy positioned the dispensary computers in a way to prevent disclosure of confidential information. The pharmacy stored completed prescriptions away from public view. And it held private information in the dispensary and rear areas, which had restricted access. The team used cordless telephones to make sure telephone conversations were held in private.

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.