General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Keith's Pharmacy, 404 Cottingham Road, HULL, North Humberside, HU6 8QE

Pharmacy reference: 1032066

Type of pharmacy: Community

Date of inspection: 16/07/2019

Pharmacy context

The pharmacy is amongst a small parade of shops in a suburb of Hull. The pharmacy dispenses NHS and private prescriptions. It supplies medicines in multi-compartmental compliance packs to help people take their medication. And it delivers medication to people's homes. The pharmacy offers the flu vaccination service. And it provides blood pressure checks on request.

Overall inspection outcome

✔ **Standards met**

Required Action: None

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Summary of notable practice for each principle

Principle	Principle finding	Exception standard reference	Notable practice	Why
1. Governance	Standards met	1.8	Good practice	The pharmacy team has training, guidance and experience to respond to safeguarding concerns to protect the welfare of children and vulnerable adults.
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	4.2	Good practice	The pharmacy has a good system for delivering medicines to people. This includes having a trained dispenser as the delivery driver. So, the team can deal with any queries promptly and effectively. The pharmacy has good systems to support the repeat prescription service. This involves the pharmacy team checking with people what medicines they need. And highlighting prescriptions that require the pharmacist to speak to the person when handing over their medication. So, people receive the correct medicines. And have information to take their medicines safely.
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. And it keeps most of the records it needs to by law. The pharmacy has written procedures that the team follows. The pharmacy has adequate arrangements to protect people's private information. The pharmacy team members respond appropriately when errors happen. And they discuss what happened and act to prevent future mistakes. The pharmacy team has training, guidance and experience to respond to safeguarding concerns. This helps to protect the welfare of children and vulnerable adults. But the pharmacy's written procedures have not been recently reviewed. This means there is a risk that team members may not be following up-to-date procedures. And they don't fully record details of the errors. This means that the team does not have information to help identify patterns and reduce mistakes.

Inspector's evidence

The pharmacy had a range of 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. The SOPs had review dates of August 2017 and April 2018. But the pharmacy hadn't completed the review. The team had read and signed the SOPs signature sheets to show they understood and would follow them. 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 mistake. The pharmacy kept records of these errors. And the team member involved completed the record. But the team members did not always record what caused the error, their learning from it and the actions they had taken to prevent the error happening again. Many entries had the same statement, pharmacist spotted, in the action taken section. Rather than details of what the team member had done to prevent the same error from happening again. The pharmacy recorded dispensing incidents on the same template as errors spotted by the pharmacist. This meant the team did not fully capture the details of the error. Such as the cause of the error, what the team had learnt and what they had done to prevent the same mistake. The team kept a copy of the prescription and the packaging of the medicine involved. One entry included a recognition by the team member involved to take a break. And to delegate more tasks to others in the team.

The team placed alert notices on shelves holding products often involved with errors. For example, an alert on the shelf holding ramipril products prompted the team members to check if they had selected tablets or capsules. Team members checked what their colleagues were doing before speaking to them. So, the colleague was not disturbed from the task they were doing. And this helped to reduce the risk of errors.

The pharmacy completed a monthly patient safety report. The team members shared the task of completing the report amongst themselves. So, everyone could understand the process and the importance of learning from errors. The team read and discussed the outcome of the report. A recent report highlighted that the team had reduced errors by ticking the details on packets such as the name and strength. So, they could show they had self-checked the item they'd dispensed. Before it went to the pharmacist for the final check. The report stated that this step had also improved the team's concentration. The report also reminded the team members to accurately record their errors.

The pharmacy had a procedure for handling complaints raised by people using the pharmacy. But it didn't display information for people to know how to raise a concern. The pharmacy team used surveys to find out what people thought about the pharmacy. The pharmacy displayed the results and published them on the NHS.uk website. The team had shared the results from a mystery shopper visit in 2018. The team received a score well above the national average.

A sample of controlled drugs (CD) registers looked at found several did not have the header completed. Some registers were not attached to the folder holding them which ran the risk of losing them. 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 records looked at found that they met legal requirements. Records of private prescription supplies 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 pharmacy had a confidentiality policy. The team members had signed the policy to show they had read it. The team had received training on the General Data Protection Regulations (GDPR). The pharmacy displayed a privacy notice in line with the requirements of the GDPR. The team separated confidential waste for shredding.

The pharmacy had safeguarding procedures and the team had access to contact numbers for local safeguarding teams. The regular pharmacists had completed level 2 training in 2017 from the Centre for Pharmacy Postgraduate Education (CPPE) on protecting children and vulnerable adults. The team had completed Dementia Friends training in 2017. The delivery driver was also a trained dispenser and reported any concerns about people she delivered to back to the pharmacy team. The team had responded well to a safeguarding concern raised with them.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy's team members have the qualifications and skills they need to provide safe and efficient services. The pharmacy offers the team opportunities to complete more training. And it provides feedback to team members on their performance. The team members share information and learning. Particularly from errors when dispensing. So, they can improve their performance and skills. The team agrees new processes and changes to support the safe and efficient delivery of the pharmacy services.

Inspector's evidence

The Superintendent Pharmacist covered most of the opening hours. Locum pharmacists provided support when required. The pharmacy team consisted of three full-time qualified dispensers, a part-time qualified dispenser who was also the delivery driver and a trainee undertaking the medicines counter assistant and dispensing courses. At the time of the inspection the Superintendent Pharmacist, two of the full-time dispensers, the delivery driver dispenser and the trainee were on duty. The pharmacy trained all team members to undertake key tasks. This supported the delivery of the pharmacy services especially at times of absence. And it helped to keep the team members focused and maintained their skills.

The pharmacy provided extra training through e-learning modules and booklets. And it kept a record of the training completed by each team member. The team were given protected time to complete the training. The pharmacy provided performance reviews to the team. So, they had a chance to receive feedback and discuss development needs.

Team members could suggest changes to processes or new ideas of working. This included placing warning cards on shelves holding products the team identified were often involved with errors. So, the team members were prompted to check the item selected. The team also agreed to focus on signing more people to the electronic (EPS) prescription service. As the team knew this was a good way of managing the workload.

The team met to discuss matters such as the outcome from the patient safety reports. The pharmacist noted the key points from the meeting in the communications diary for team members who could not attend the meeting. The pharmacist also used a notice board in the dispensary to record this information. The pharmacy had targets for services such as Medicine Use Reviews (MURs). There was no pressure to achieve them. The pharmacist 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. The pharmacy has good arrangements for people to have private conversations with the team. The pharmacy owners recognise the limitations of the current layout of the pharmacy to support the effective delivery of pharmacy services. And are taking several steps to address this.

Inspector's evidence

The pharmacy was clean, tidy and hygienic. It had separate sinks for the preparation of medicines and hand washing. The pharmacy had notices advising the team members on the correct method for washing their hands. The consultation room contained a sink and the pharmacy had alcohol gel for hand cleansing.

The team kept floor spaces clear to reduce the risk of trip hazards. The pharmacy had enough storage space for stock, assembled medicines and medical devices. The team was changing the layout of the pharmacy to make more room for dispensing. And for storing medicines. The team had relocated the section holding completed prescriptions awaiting supply to nearer the pharmacy counter. This meant the team could easily locate the person’s prescription. And the section was out of sight of anyone at the pharmacy counter. The team were planning to install a computer near this section to scan the prescriptions at the point of supply. So, the team could meet the requirements of the Falsified Medicines Directive (FMD). The pharmacy had a large, sound proof consultation room. The team used this for private conversations with people. The pharmacy had a notice informing people of the availability of the room.

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 provides services that support people's health needs. The pharmacy manages its services well. It keeps records of prescription requests. And it takes care when dispensing medicines in to multi-compartmental compliance packs to help people take their medication. The pharmacy has a good system for delivering medicines to people. This includes having a trained dispenser as the delivery driver. So, the team can deal with any queries promptly and effectively. The pharmacy has good systems to support the repeat prescription service. This involves the pharmacy team checking with people what medicines they need. And highlighting prescriptions that require the pharmacist to speak to the person when handing over their medication. So, people receive the correct medicines. And have information to take their medicines safely. The pharmacy gets is medicines from reputable sources. And it stores and manages medicines appropriately.

Inspector's evidence

The pharmacy's window displays detailed the opening times and the services offered. The team had access to the internet to direct people to other healthcare services. The pharmacy offered a blood pressure service. And it had trained several members of the team to take people’s blood pressure readings and to know when to refer to the pharmacist and person’s GP. The team provided people with a blood pressure monitor to use at home for a week. So, a comprehensive set of readings could be obtained. And the team could identify if the person should be referred to their GP. The pharmacy kept a good range of information leaflets from the British Heart Foundation for people to read and take away.

The pharmacy provided multi-compartmental compliance packs to help around 31 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. The pharmacy had a list of people who received the packs. And the team used this to record when to order the prescriptions and when the prescriptions arrived at the pharmacy. 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, dosage and dose times. The team checked received prescriptions against the list and the backing sheet supplied with the packs. And queried any changes with the GP team.

The team referred to the medication list, as well the prescription, throughout the dispensing and checking of the packs. One of the dispensers labelled the prescriptions and picked the stock. Another dispenser or the pharmacist checked the medicines picked before the items were put in to the packs. The team used a table in a room to the rear of the dispensary when dispensing the medication in to the packs. This was away from the distractions of the main dispensary and retail area. The team recorded the descriptions of the products within the packs to help people identify their medicines. And it supplied the manufacturer’s patient information leaflets. The team stored completed packs on dedicated shelves. The pharmacist bagged the packs on the day they were due out and placed them in the delivery box. The pharmacy rarely received copies of hospital discharge summaries. The person or their representative sometimes provided the discharge information. The team checked the discharge summary against the medication list to spot changes or new items. And the team recorded changes on to the medication list. The pharmacy also provided administration charts for people to record when they had taken their medicines.

The team members provided a repeat prescription ordering service. They used a system to remind them when they had to request the prescriptions. And they kept an audit trail to track the requests. 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 contacted the person to ask what medicines such as creams they needed. The team regularly checked the record of 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 marked completed prescriptions awaiting collection to highlight when the pharmacist needed to speak to the person. The pharmacy team had completed checks to identify patients that met the criteria of the valproate Pregnancy Prevention Programme (PPP). The team printed out the audit and marked it to show if the person met the PPP criteria and if they had seen the GP. The team put notes on the electronic patient medication record (PMR) for people who met the criteria. The pharmacy had the PPP pack to provide people with information when required. The pharmacy team asked people taking high risk medicines such as warfarin for information about blood tests and doses. But it didn't record this information when given.

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. This helped to ensure they picked the correct item. The pharmacy used clear bags to hold dispensed fridge lines. This allowed the team, and the person collecting the medication, to check the supply. The pharmacy had a system to prompt the team to check that supplies of controlled drugs (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 delivery driver was a trained dispenser so could pass on to the person information from the pharmacist. And answer people’s questions about their medicines. If the dispenser could not answer the question she made a note to ask the pharmacist. The driver telephoned each person before taking their medicines out. So, the driver could check that the person was at home and make alternate arrangements if the person was out. The driver often collected prescriptions for people after the person informed the driver they were waiting for a prescription for items such as antibiotics. The driver collected the prescription, took it to the pharmacy and returned to the person with their medicine. This enabled the person to start their medicine as soon as possible.

The pharmacy team members checked the expiry dates on stock. And they kept a record of this by marking the section they had completed. The team used a sticker to highlight medicines with a short expiry date. And it kept a list of products due to expire each month. No out of date stock was found. The team members usually 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 Sytron liquid with three months use once opened had a date of opening of 04 July 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 equipment to meet the requirements of the Falsified Medicines Directive (FMD). The pharmacist had printed off FMD guidance that the team had read. The team members were scanning FMD compliant packs. 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 pharmacist printed off the alert, actioned it and kept a record. And all the team read the alert.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide safe services and 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 it had a fridge to store medicines kept at these temperatures. The team used a Rossmax blood pressure monitor when measuring people's blood pressure.

The pharmacy computers were password protected and access to peoples’ 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.