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: 04/10/2022

Pharmacy context

This community pharmacy is amongst a small parade of shops in a suburb of Hull. The pharmacy dispenses NHS prescriptions and supplies some medicines in multi-compartment compliance packs to help people take their medication. It offers a range of other services including the seasonal flu vaccination service and the NHS COVID-19 vaccination service.

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	Good practice	2.2	Good practice	The pharmacy actively encourages and supports team members to develop their skills and knowledge. And it provides protected time at work for team members to complete their training.
		2.5	Good practice	The pharmacy is good at encouraging team members to share ideas on how to improve the delivery of services through regular meetings. And they actively engage in providing feedback on any changes that may affect their ways of working.
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 well. It has up-to-date written procedures that the pharmacy team follows. And it completes all the records it needs to by law. Team members suitably protect people's confidential information and they understand their role to help protect vulnerable people. Team members respond competently when errors occur, they discuss what caused the error and they act to prevent future mistakes.

Inspector's evidence

The pharmacy had a range of up-to-date standard operating procedures (SOPs) that provided the team with information to perform tasks supporting the delivery of services. The SOPs were held in clearly labelled folders so they were easily located and separate folders held the SOPs covering specific services such as the flu vaccination service. The team members had read and signed the SOPs signature sheets to show they understood and would follow the SOPs. They demonstrated a clear understanding of their roles and worked within the scope of their role.

The pharmacy had a procedure for managing errors identified during the dispensing process known as near misses. The team members recorded their near miss errors to capture the cause of the error, their learning from it and the action they'd taken to prevent the error from happening again. A sample of records showed a range of reflections and learning recorded by the team. The pharmacy had a procedure for managing errors that had been identified after the person had received their medicine, known as dispensing incidents. The dispensing incident was shared with all team members so they could learn from it. And it was captured on the pharmacy's electronic patient medication record (PMR) to remind the team. The team members regularly reviewed and discussed the near miss errors and dispensing incidents to identify actions they could take to reduce such errors. This included using the PMR to clearly highlight the formulation of a product the person required. And separating medicines that looked and sounded alike (LASA) with stickers attached to shelves holding these products to prompt the team to check the product selected. The pharmacy had a procedure for handling complaints raised by people using the pharmacy services.

The pharmacy had up-to-date indemnity insurance. A sample of records required by law such as the Responsible Pharmacist (RP) records and controlled drug (CD) registers met legal requirements. The pharmacy completed regular balance checks of the CD registers to help identify errors such as missed entries. The team members had completed training about the General Data Protection Regulations (GDPR) and they separated confidential waste for shredding offsite. The pharmacy offered people a form to write their personal details on when presenting at the pharmacy which the team used to access the PMR. So, the person didn't have to give this information out loud, in front of other people. And it helped reduce the risk of the team selecting the wrong person when accessing the PMR. The team appropriately disposed of the forms after they'd been used.

The pharmacy had safeguarding procedures for the team to follow. Team members had completed appropriate training including the pharmacist who had completed level 2 training from the Centre for Pharmacy Postgraduate Education (CPPE) on protecting children and vulnerable adults. The delivery driver reported concerns about people they delivered to, back to the pharmacy team who took appropriate action such as contacting the person's GP.

Principle 2 - Staffing ✔ Good practice

Summary findings

The pharmacy has an experienced team with the qualifications and skills to safely provide its services. It encourages an open and honest culture where team members work very well together. Team members benefit from identifying areas of their own practice they wish to develop, and the pharmacy helps them to achieve this. The pharmacy supports ongoing training for team members so they can suitably develop their skills and knowledge. And they discuss ideas and implement new processes to enhance the delivery of the pharmacy's services.

Inspector's evidence

The pharmacist owner who was also the Superintendent Pharmacist (SI) along with regular locum pharmacists covered the opening hours. The pharmacy team consisted of two full-time dispensers, two part-time dispensers, a medicines counter assistant who was also the delivery driver and a team member who provided administration support. The team members worked well together and rotated amongst themselves key tasks such as labelling and dispensing of prescriptions throughout the day. This helped to ensure everyone remained focused on the task they were responsible for. The team had developed a list of key tasks to be completed each day and each team member initialled the list to indicate when they'd completed a task. This ensured the tasks were completed especially at times when team numbers were reduced such as unplanned absence.

The team members accessed a range of online training modules to keep their knowledge up to date and received training certificates that were kept in the pharmacy for reference. The SI monitored the team's completion of the training and provided protected time at work for the training. The team members used the daily list of tasks to identify suitable times in the day to do their training. The team members, after completing training about sepsis, had created an information leaflet about the condition that was handed to people when they collected prescriptions for antibiotics.

The SI was the only trained vaccinator for the flu and COVID-19 vaccination services but the locum pharmacist was completing training to support the SI. The SI had provided the team members with training and guidance on how adrenaline worked and where it was located. So, they were aware of its use in an emergency and could direct the pharmacist on duty to its location.

The team members held daily meetings to plan the day ahead and they could suggest changes to processes or new ideas of working. For example, at a recent meeting the team had discussed and agreed to move the section holding prescriptions awaiting stock so the prescriptions could be completed as soon as the medication arrived from the wholesalers. The pharmacy provided team members with feedback on their performance and supported those who wished to progress and develop their skills. One of the dispensers had expressed interest in training to be a pharmacy technician and taking on some managerial roles. The SI created a programme of additional responsibilities for the dispenser to manage as part of their development and planning for the technician course.

Principle 3 - Premises ✔ Standards met

Summary findings

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

Inspector's evidence

The pharmacy premises were tidy and hygienic. In response to the COVID-19 pandemic the pharmacy team wore face masks and the pharmacy had installed clear plastic screens on the pharmacy counter. The team asked people attending for the flu and COVID vaccination services to wear face masks when they entered the consultation room. The team regularly used hand sanitiser and people using the pharmacy had access to hand sanitiser. The team used separate sinks for the preparation of medicines and hand washing and they kept floor spaces clear to reduce the risk of trip hazards. The pharmacy had enough storage space for stock, assembled medicines and medical devices. And it had a defined professional area where items for sale were healthcare related.

The pharmacy had an appropriately sized soundproof consultation room that the team used for private conversations with people and when providing pharmacy services. The SI had rearranged the furniture in the room so there was space to support someone who felt unwell after receiving the flu and COVID vaccinations. The pharmacy had restricted public access to the dispensary during the opening hours.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's services are easily accessible and help people to meet their healthcare needs. The team manages its services well and makes sure people receive their medicines when they need them. Team members support people with advice and healthcare information. They store medicines properly and they regularly carry out checks to make sure medicines are in good condition and suitable to supply.

Inspector's evidence

People accessed the pharmacy via a step free entrance. The team members provided people with information on how to access other healthcare services when required and they wore name badges so people knew who they were speaking to. The pharmacy provided the NHS hypertension case finding service and several people had accessed the service. The pharmacist had referred a few people to their GP after monitoring their blood pressure readings. The team asked appropriate questions of people requesting over-the-counter medicines and knew when to refer to the pharmacist. The computer on the pharmacy counter had access to the PMR so, when a person presented the team member could check what stage the dispensing of their prescription was at.

The pharmacy provided services such as the seasonal flu vaccination and the COVID-19 vaccination against up-to-date patient group directions (PGDs). The PGDs gave the pharmacist the authority to administer the vaccine. The pharmacy provided the flu vaccination and COVID-19 vaccination services through booked appointments. The team managed the bookings by having two lists, one for days that were fully booked and another listing available appointments. The bookings were usually offered for set hours in the morning and afternoon so the pharmacist had sometime during the day to catch-up with other tasks such as checking prescriptions. If there was some vaccine remaining after everyone booked in for that day had been or when someone cancelled a booking the team contacted people to offer an earlier appointment. The team worked well together to support the service and manage the pharmacy’s other services, for example urgent prescriptions were given priority so the pharmacist could check them between appointments. The team members printed off the list of people booked in each day so they could record when the person had been. And they asked appropriate questions of the person presenting at the pharmacy as part of the booking-in process. The SI had produced additional information on to a sheet about the different needles to be used when administering the vaccines so the pharmacist could easily refer to it. The pharmacy had up-to-date adrenaline injections in the consultation room in case of an anaphylactic reaction to the vaccine.

The pharmacy provided multi-compartment compliance packs to help around 15 people take their medicines. The team members managed the workload by usually ordering the prescriptions one week before supply to allow time to deal with issues such as missing items. And they kept a record of the completion of each stage of the dispensing of the packs. So, the team had this information available if queries arose. The pharmacy kept a record listing each person’s current medication and dose times. The team checked prescriptions against the list to identify any changes and these were queried with the prescriber. The team recorded the descriptions of the products within the packs and supplied the manufacturer’s packaging leaflets. This meant people could identify the medicines in the packs and they had information about their medicines. The pharmacy received copies of hospital discharge summaries via the NHS Discharge Medicines Service. The team checked the discharge summary for changes or new items and liaised with the prescriber before updating the person’s medication list.

The team provided people with clear advice on how to use their medicines. And the pharmacist recorded conversations with people about their medication on to the PMR to support their ongoing care. The team had generated an information leaflet about sepsis that was handed to people prescribed antibiotics. The team gave a brief explanation of the leaflet to the person when handing out the prescribed antibiotics and answered any questions they had. The team members were aware of the criteria of the valproate Pregnancy Prevention Programme (PPP) and described how they always ensured the label didn't cover the patient card, which was embedded in the manufacturer's packaging. If they supplied valproate in a plain white box they provided the PPP information card along with the warning stickers and the manufacturer's packaging leaflets.

The pharmacy provided separate areas for labelling, dispensing and checking of prescriptions. The team used baskets during the dispensing process to isolate individual people's medicines and to help prevent them becoming mixed up. Usually, different team members labelled and dispensed the prescriptions. The pharmacy had checked by and dispensed by boxes on the dispensing labels. These recorded who in the team had dispensed and checked the prescription and a sample found the team completed the boxes. The team also recorded on the prescription token who had labelled, dispensed and checked the prescription tokens. The pharmacy used CD and fridge stickers on bags and prescriptions to remind the team when handing over medication to include these items. When the pharmacy didn't have enough stock of someone's medicine, it provided the person with a printed slip detailing the owed item. The pharmacy kept a record of the delivery of medicines to people. The pharmacist used the delivery record to detail any information to be passed onto the person or to request the person to contact the pharmacy for advice.

The pharmacy obtained its medicine stock from several reputable sources. The team members regularly checked the expiry dates on stock and kept a record of this. They marked medicines with a short expiry date to prompt them to check the medicine was still in date. No out-of-date stock was found. The dates of opening were recorded for medicines with altered shelf-lives after opening. This meant the team could assess if the medicines were still safe to use. The team members checked and recorded fridge temperatures each day and a sample of these records 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 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 received alerts about medicines and medical devices from the Medicines and Healthcare products Regulatory Agency (MHRA) via email. The team usually 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 its services safely. It makes sure it uses its equipment appropriately to protect people's confidential information.

Inspector's evidence

The pharmacy had reference sources and access to the internet to provide the team with up-to-date clinical information. It had equipment available for the services provided including a range of CE equipment to accurately measure liquid medication. It had a fridge to store medicines kept at these temperatures. The computers were password protected and access to people's records was restricted by the NHS smart card system. The pharmacy positioned the computer on the pharmacy counter in a way to prevent disclosure of confidential information. It stored completed prescriptions away from public view and it held private information in the dispensary which had restricted public access.

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.