General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Bransholme Pharmacy, Unit 53 48 Goodhart Road, North Point Shopping Centre, Bransholme, HULL, North Humberside, HU7 4EE

Pharmacy reference: 1032079

Type of pharmacy: Community

Date of inspection: 26/02/2024

Pharmacy context

This community pharmacy is in a large shopping centre in a suburb of Hull. The pharmacy's main activities are dispensing NHS prescriptions. And it provides several people with their medicines in multi-compartment compliance packs to help them take their medication correctly. The pharmacy provides other NHS services such as the Pharmacy First service and the Hypertension Case Finding Service.

Overall inspection outcome

Standards not all met

Required Action: Improvement Action Plan

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 not all met	1.6	Standard not met	The pharmacy does not keep all its records correct and accurate. This includes the legal records involving higher risk medicines.
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 not all met	4.3	Standard not met	The pharmacy does not store all its medicines safely. And it does not maintain records to show it appropriately monitors the temperatures some medicines are stored at to ensure they remain safe to supply.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance **Standards not all met**

Summary findings

The pharmacy adequately identifies and manages the risks associated with its services. But it does not always complete the records it needs to by law. So, the pharmacy does not have a complete record of all the supplies of its higher-risk medicines. It has written procedures that the pharmacy team generally follows, and it protects people's private information correctly. Team members respond appropriately when errors occur, they discuss what happened and they take action to prevent future mistakes. But they don't always record their errors so they may miss opportunities to learn from their mistakes and reduce the risks of mistakes happening again.

Inspector's evidence

The pharmacy had a range of standard operating procedures (SOPs) that were kept electronically. These provided the team with information to perform tasks supporting the delivery of services. SOPs with review dates of January 2024 were in the process of being reviewed. The full-time dispenser who recently started in post was reading the SOPs before signing off the signature sheets to show they understood and would follow the SOPs. The other team members including the Superintendent Pharmacist (SI) had signed SOP signature sheets at other pharmacies owned by the company. The team members 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 of prescriptions, known as near miss errors. The team member involved was asked to identify their error, correct it and record it. However, a sample of near miss records showed only a few entries. There was an entry on 23/12/2023 and the next entry was dated 16/02/2024. The records that were made showed that the team member had reflected on the error and identified how to prevent the same error from happening again. Separate records were kept for errors identified after the person received their medicine, known as dispensing incidents. All team members were informed of the dispensing incident, so they were aware. And they were informed of the actions taken to prevent the error from happening again. Team members had separated amitriptyline and amlodipine to prevent these medicines from being picked in error. And after a dispensing incident involving the wrong quantity of medication the team was reminded to clearly mark containers after removing some of the medication from the original pack. The pharmacy had a procedure for handling complaints raised by people using the pharmacy services. And team members monitored feedback left by people on social media platforms.

The pharmacy had current indemnity insurance. A sample of Responsible Pharmacist (RP) records met legal requirements. And the RP clearly displayed their RP notice, so people knew details of the pharmacist on duty. A sample of entries that had been made in controlled drug (CD) register met legal requirements. But several CD prescriptions and CD invoices had not been entered into the registers. To support the NHS Pharmacy First service the pharmacy had a range of patient group directions (PGDs). These provided the legal framework for the pharmacist to provide medication such as antibiotics. And had been signed by the pharmacist to show they had read them, understood them and would follow them.

Team members followed the SOPS about the General Data Protection Regulations (GDPR), and they separated confidential waste for shredding offsite. The pharmacy had safeguarding procedures and guidance for team members to follow, and they had access to contact numbers for local safeguarding teams. The SI had not updated their training since 2018.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has a small team with an appropriate range of skills and experience to support its services. Team members work well together and support each other in their day-to-day work. They complete limited ongoing training and development. So, they may miss the chance to further develop their skills and knowledge.

Inspector's evidence

The Superintendent Pharmacist (SI) worked full time at the pharmacy with regular locum pharmacists providing support mostly on a Saturday. The pharmacy team consisted of a full-time qualified dispenser who had been in post one month and a full-time locum dispenser. The newly appointed dispenser had protected time at work to read the SOPs and familiarise themselves with the pharmacy's processes. The pharmacy also employed a part-time delivery driver who had been in post since December. The driver had received some training provided by the SI but was yet to be enrolled onto an accredited training course. The SI was recruiting for another full-time team member as the team's workload was increasing. At the time of the inspection all team members were on duty. Team members worked well together and supported each other.

In preparation for the NHS Pharmacy First service the SI had completed online training and face-to-face training that included the use of an otoscope for examining ears. Additional training for team members was limited to regulatory training and learning from errors. They received informal feedback from the SI when appropriate and were encouraged to use their experience to suggest changes to processes. The SI regularly met with other pharmacists in the company and shared key points from these meetings with team members.

Principle 3 - Premises ✔ Standards met

Summary findings

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

Inspector's evidence

The pharmacy premises were tidy and there was enough storage space for stock, assembled medicines and medical devices. Team members kept floor spaces clear to reduce the risk of trip hazards. There was a defined professional area and items for sale in this area were healthcare related. The pharmacy generally had separate sinks for the preparation of medicines and hand washing. And there was a soundproof consultation room which team members used for private conversations with people and when providing services. But there was no sink or alcohol gel for hand cleansing in the room. The pharmacy was secure and there was restricted public access to the dispensary during the opening hours.

Principle 4 - Services **Standards not all met**

Summary findings

The pharmacy does not always store and manage all its medicines in a safe manner. So, there is a risk that some medicines may be supplied that are not fit for purpose. The pharmacy provides a range of services that support local people's health needs, and it suitably manages its services to help people receive appropriate care.

Inspector's evidence

People accessed the pharmacy directly from the shopping centre. A few people had accessed the NHS Pharmacy First service, mostly for sinusitis and ear infections. The SI had spoken to pharmacists in the area to discuss how to raise awareness of the service and ensure there were appropriate referrals from the local GP teams. The NHS hypertension case finding service was popular and had resulted in some people being referred for further tests. Team members attached stickers to prescriptions to prompt them to discuss the service with people when they collected their medication. And invited them to have their blood pressure checked.

The pharmacy provided multi-compartment compliance packs to help several people take their medicines. To manage the workload the team divided the preparation of the packs across the month. Each person had a record listing their current medication and dose times which the team referred to during the dispensing and checking of the medicines dispensed into the packs. 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 had information about their medicines.

The pharmacy supplied medicine to some people daily as supervised and unsupervised doses. The doses were prepared in advance of supply to reduce the workload pressure of dispensing at the time of supply. And they were stored securely with each person’s prepared doses separated in baskets. This helped to reduce the risk of the person receiving the wrong dose. An additional check was done with the person at the time they presented for their dose and included asking for their date of birth. The pharmacist checked the response against the prescription before the dose was handed over.

The team provided people with clear advice on how to use their medicines. Team members were aware of the criteria of the valproate Pregnancy Prevention Programme (PPP). And the recent changes requiring valproate to be dispensed in the manufacturer’s original pack. They advised that no-one prescribed valproate met the criteria.

The pharmacy provided separate areas for labelling, dispensing and checking of prescriptions. Baskets were used during the dispensing process to isolate individual people’s medicines and to help prevent them becoming mixed up. Pharmacy team members initialled ‘dispensed by’ and ‘checked by’ boxes on dispensing labels, to record their actions in the dispensing process. The pharmacy used 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 a printed slip detailing the owed item. The pharmacy kept a record of the delivery of medicines to people.

The pharmacy obtained medication from several reputable sources and it securely stored CDs. Team members checked the expiry dates on stock and generally marked medicines with a short expiry date to prompt them to check the medicine was still in date. Two medicines with expiry dates in June 2024

were found unmarked. Team members recorded the dates of opening for medicines with altered shelf-lives after opening. So, they could assess if the medicines were still safe to use. The team kept medication removed from the original packs in bottles. Many of these bottles weren't labelled with details of the medication inside or the batch number and expiry date of the medicine. This practice meant the team members would not know if the medication was in date and they couldn't identify if the bottle contained affected stock if a safety alert came through. The team regularly checked fridge temperatures but did not always keep a record. The temperatures of both fridges at the time of the inspection were in the correct range. The pharmacy had medicinal waste bins to store out-of-date stock and returned medication. 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 safe services and it uses its facilities to suitably 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 information. There was equipment available for the services provided which included a range of CE equipment to accurately measure liquid medication. And two fridges for holding medicines requiring storage at this temperature. The fridges had glass doors that enabled the team to view stock without prolonged opening of the door.

The pharmacy 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 areas 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.