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: 12/09/2024

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 met**

Required Action: None

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 met	N/A	N/A	N/A
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	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 suitably identifies and manages the risks associated with its services. It has written procedures that team members follow to help ensure they provide the pharmacy's services safely. And it keeps the records it needs to by law. The pharmacy protects people's private information, and it provides team members with training to help them respond correctly to safeguarding concerns to help vulnerable people. Team members respond appropriately when mistakes happen by identifying what caused the error and acting to prevent future mistakes.

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 team had read and signed the SOPs' signature sheets to show they understood and would follow them. 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. The records 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. 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, showing improvements from the previous insection. Since the last inspection the Superintendent Pharmacist (SI) had introduced a system to ensure entries were not missed. All CD prescriptions after the person had received their medication and invoices of CDs received from the wholesaler were placed in a basket. The SI completed the register entries towards the end of each day. 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 completed training relevant to their role.

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 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 and a full-time locum dispenser. A full-time dispenser had recently been recruited and was due to start the week after the inspection. The pharmacy also employed a part-time delivery driver who worked one day a week and had been in post since December. They had received internal training from the SI and had recently enrolled on to an appropriate training course. 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.

Principle 3 - Premises ✔ Standards met

Summary findings

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

Inspector's evidence

The pharmacy premises were clean and tidy. There was enough storage space for stock, assembled medicines and medical devices. Team members generally kept floor spaces clear to reduce the risk of trip hazards. A few baskets containing prescriptions and dispensed medicines were on the floor next to one of the dispensing benches. There was a defined professional area and items for sale in this area were healthcare related. The pharmacy 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. The pharmacy was secure and it had restricted public access during its opening hours.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides a range of services which are easily accessible for people. Team members manage the pharmacy services well to help people receive appropriate care and to make sure people receive their medicines when they need them. The pharmacy obtains its medicines from recognised suppliers and it stores them properly. The team carries out suitable checks to make sure medicines are in good condition and safe to supply.

Inspector's evidence

People accessed the pharmacy directly from the shopping centre. A few people had accessed the NHS Pharmacy First service and the SI was promoting the service to people to raise awareness of the service. The NHS hypertension case finding service was popular and had resulted in some people being referred for further tests. Team members marked prescriptions to prompt them to discuss the service with people when they collected their medication. And invited them to have their blood pressure checked. Team members were preparing to provide the NHS seasonal flu vaccination service by offering appointments to people enquiring about the service.

The pharmacy provided multi-compartment compliance packs to help several people take their medicines. Team members had paused the recruitment of new people to the service to ensure they could continue to provide it safely. 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.

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 SI had updated the team regarding the addition of topiramate to the PPP and the latest advice for men taking valproate.

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. When the pharmacy didn't have enough stock of someone's medicine, it provided a printed slip detailing the owed item. People received a text message from the pharmacy advising them when their prescription was ready to collect. And a reminder was sent after a few weeks if the person had not collected their prescription. The pharmacy kept a record of the delivery of medicines to people.

The pharmacy obtained medication from several recognised sources and it securely stored CDs. It stored medicines tidily on shelves and in drawers. Team members checked the expiry dates on stock

and marked medicines with a short expiry date to prompt them to check the medicine was still in date. 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 regularly checked fridge temperatures and kept a record. A sample showed the temperatures of both fridges were in the correct range. This had improved since the last inspection. 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 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 reference 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.