General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Brocklehurst Chemists, 801 Hotham Road South, HULL, North Humberside, HU5 5JX

Pharmacy reference: 1032088

Type of pharmacy: Community

Date of inspection: 12/09/2024

Pharmacy context

This community pharmacy is in a suburb of Hull. The pharmacy dispenses NHS prescriptions and sells over-the-counter medicines. The pharmacy provides other NHS services including the Pharmacy First service and hypertension case finding service. The pharmacy has an automated prescription collection point that allows people to collect their medication 24-hours a day, seven days a week.

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	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 identifies and manages the risks associated with its services well. It has up-to-date written procedures that the team members follow to help ensure they provide the pharmacy's services safely. And it generally keeps 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 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 up-to-date standard operating procedures (SOPs) that provided the team with information to perform tasks supporting the delivery of its services. Team members had read and signed the SOPs' signature sheets to show they understood and would follow them. They demonstrated a clear understanding of their roles and worked within the scope of their role.

Team members were asked to find and correct errors spotted at all stages of dispensing a prescription. For example, when a team member attaching a dispensing label noticed the wrong medication had been selected. And when the final check by the accuracy checking pharmacy technician (ACPT) identified an error. Electronic records of these errors, known as near miss errors, were made after the team member involved was informed of their error. There was a separate procedure for managing errors identified after the person received their medicine, known as dispensing incidents. All team members were informed of the dispensing incident so they could learn from it. And were aware of the actions taken to prevent such errors from happening. A record of the dispensing incident was made on the pharmacy's electronic patient medication record (PMR) to remind team members of the error. To help reduce the risk of errors when dispensing prescriptions different team members selected the medicine for dispensing and generated the dispensing label. Team members reported a reduction in picking errors when this step was introduced. The pharmacy undertook a regular review of the near miss errors and dispensing incidents. And the outcome was shared with team members who discussed the changes they could make to prevent future errors. A recent review alerted team members to medicines that looked alike and sounded alike to remind them to double check the medicine they selected from the shelves. The pharmacy had a procedure for handling complaints raised by people using the pharmacy services. And people could raise a concern directly with the team or via the pharmacy's website.

The pharmacy had current indemnity insurance. A sample of records required by law such as the Responsible Pharmacist (RP) records and controlled drug (CD) registers generally met legal requirements. The pharmacists regularly checked the balance of CDs in the registers against the physical stock to identify any issues such as missed entries. Appropriate records were kept of CDs returned by people and the CDs were promptly destroyed. The RP clearly displayed their RP notice, so people knew details of the pharmacist on duty. However, the RP didn't always record when they stopped being the RP. To support the NHS Pharmacy First service the pharmacy had a range of patient group directions (PGDs). These provided the legal framework for the pharmacists to provide medication such as antibiotics. And they had been signed by the pharmacists to show they had read them, understood them and would follow them.

The company's website displayed details on the confidential data kept and how it complied with legal

requirements to protect people's private information. Team members had completed training about the General Data Protection Regulations (GDPR) and they separated confidential waste for shredding offsite. The pharmacy had safeguarding procedures and guidance for the team to follow. And team members had completed training relevant to their roles.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has a team with a good range of experience and skills to safely provide its services. Team members work well together and are good at supporting each other in their day-to-day work. They discuss ideas and implement processes to enhance the safe and effective delivery of the pharmacy's services. Team members have opportunities to receive feedback and complete training so they can suitably develop their skills and knowledge.

Inspector's evidence

Regular locum pharmacists covered the pharmacy's opening hours. The pharmacy team consisted of one part-time pharmacy technician, four ACPTs, one who was the pharmacy manager, one full-time dispenser, two part-time dispensers and one medicines counter assistant. Team members worked well together and supported each other. All team members were trained or being trained on how to undertake key tasks. And a daily rota ensured there was always one team member working at the pharmacy counter, so people were not kept waiting. The rota also ensured key tasks such as labelling prescriptions were completed especially at times of planned and unplanned absence.

Team members used online training modules to keep their knowledge up to date. And they had protected time at work to complete the training. The team held regular meetings where team members discussed information from head office and reviewed how they could support the pharmacy's services. And they had been granted to occasionally close an hour over the lunch period for longer meetings or training sessions. People were given advanced notice of this. Team members regularly received formal and informal feedback on their performance. And they had opportunities to develop their knowledge and skills. The pharmacy manager had been in post one year having previously been in the supervisor role.

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 hygienic and tidy, the pharmacy employed a cleaner to support the team to keep the pharmacy clean. The pharmacy had separate sinks for the preparation of medicines and hand washing. 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. The installation of the automated prescription collection point was carefully planned and had not impacted on the workspaces in the pharmacy. There was a defined professional area and items for sale in this area were healthcare related. And there was a large, well equipped 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 sources, and it stores them properly. The team regularly carries out checks to make sure medicines are in good condition and are suitable to supply.

Inspector's evidence

People accessed the pharmacy via a step-free entrance. Posters on the door and in the retail area informed people when the pharmacist was on lunch so prescriptions could not be handed out. Another poster displayed on the pharmacy counter advised people of the waiting time for prescriptions so they could choose to wait or come back. This helped the team manage its workload and reduced the number of people waiting in the small retail area. The pharmacy used a social media platform to promote its services and other information such as its opening hours. The pharmacy had an eye-catching display promoting the hypertension case finding service and the importance of monitoring blood pressure. Two team members were trained to take people's blood pressures to support the pharmacist to deliver the service. Other team members were completing the training. Team members asked appropriate questions of people requesting to buy over-the-counter medicines to ensure the correct product was supplied. And they knew when to refer requests to the pharmacist.

Team members were aware of the criteria of the valproate Pregnancy Prevention Programme (PPP). And the recent updates including valproate to be dispensed in the manufacturer's original pack and the advice for men taking valproate. The pharmacists ensured people prescribed valproate who met the criteria had a PPP in place. And recorded this on the PMR so all team members were aware. Team members had also received the update regarding the requirements for people taking topiramate to have a PPP and were checking for people prescribed this medication. The computer on the pharmacy counter had access to the PMR so team members could check what stage a person's prescription was at when they presented at the pharmacy.

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. Team members initialled dispensed by and checked by boxes on dispensing labels, to record their actions in the dispensing process. And they used a separate system to capture the pharmacist's clinical check which enabled the ACPT to complete their check. The pharmacy used clear bags to hold dispensed fridge lines, this enabled the team, and the person collecting the medication, to check the supply. 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 either at the pharmacy or from the automated prescription collection point, which included a unique collection code. The collection point was popular and team members promoted this service to encourage more people to use it and reduce the number of people presenting at the pharmacy. CDs and medicines requiring storage in a fridge were not stored in the collection point. And prescriptions that needed the pharmacist to speak to the person or to offer a service such as the NHS New Medicines Service were not kept in the collection point. The pharmacy kept prescriptions in the collection point for seven days. Team members removed uncollected prescriptions every Monday and stored them in a dedicated area before contacting the person. This

provided space for a new set of completed prescriptions to be placed into the collection point.

The pharmacy obtained its medication from recognised sources. Team members stored the medication tidily on shelves and in drawers, and they securely stored CDs. Team members checked the expiry dates on stock and marked medicines that were approaching their expiry date to prompt them to check the medicine was still in date when dispensing. No out-of-date stock was found. 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 checked and recorded fridge temperatures each day and a sample of these records showed the temperatures were within the correct range. The pharmacy had medicinal waste bins to store out-of-date stock and returned medication. And the team used appropriate denaturing kits to destroy CDs. The pharmacy received safety alerts and recalls about medicines and medical devices from the Medicines and Healthcare products Regulatory Agency via email. The team printed off the alert, actioned it and kept a record. Following a recent alert team members identified people prescribed the affected medication and contacted them to check whether they had any of the affected stock. And they had removed from the pharmacy shelves any packs of the medication meeting the alert criteria.

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 marked 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. Team members used labelled baskets to store dispensed prescriptions in the fridge to separate them from stock and make them easier to locate. The pharmacy computers were password protected and access to people’s records restricted by the NHS smart card system. Team members used cordless telephones to ensure their conversations with people were held in private. 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.