General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: City Health Pharmacy, Victoria Dock Health Centre, 81 South Bridge Road, HULL, North Humberside, HU9 1TR

Pharmacy reference: 1032124

Type of pharmacy: Community

Date of inspection: 24/07/2019

Pharmacy context

The pharmacy is next door to a small GP surgery in a suburb of Hull. The pharmacy dispenses NHS and private prescriptions. And it delivers medication to people's homes. The pharmacy offers a blood pressure checking service. And it supplies medication to help people stop smoking.

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	2.5	Good practice	The pharmacy team members receive feedback on their performance. And they proactively share opinions on the delivery of pharmacy services. Which are followed up and acted upon.
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 generally identifies and manages the risks associated with its services. And people using the pharmacy can raise concerns and provide feedback. The pharmacy has appropriate arrangements to protect people's private information. And the pharmacy team has some level of training and guidance to respond to safeguarding concerns to protect the welfare of children and vulnerable adults. The pharmacy keeps most of the records it needs to by law. And the pharmacy has written procedures for the team to follow. But few team members have signed to say they've read the procedures. This means there is a risk they may not understand or follow correct procedures. The pharmacy team members respond well when errors happen. And they discuss what happened and act to prevent future mistakes. But they don't always complete full records of errors or review the mistakes. This means that the team does not have complete information to help identify patterns and reduce errors.

Inspector's evidence

The pharmacy had a range of standard operating procedures (SOPs). The company was reviewing the SOPs. The SOPs 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. Only the pharmacist manager 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. A sample of the error records looked at found that the team sometimes recorded details of what had been prescribed and dispensed to spot patterns. But team members did not always record what caused the error, their learning from it and actions they had taken to prevent the error happening again. The pharmacy team recorded dispensing incidents. A recent report detailed the supply of the wrong strength of a product. The team members identified the cause was a build-up of baskets awaiting checking. And they agreed moving forward to only pass on one basket at a time to the pharmacist. The company shared information from dispensing incidents amongst the pharmacy teams. The team responded to information from the company about an error with insulin. The team discussed the impact on people of this type of mistake. And reminded each other to show the person the dispensed insulin. So, the person could confirm it was the product they were expecting. The team also discussed placing the insulin in clear bags to support this. The team discussed the company decision to change suppliers. And identified the change had resulted in several medicines with similar packaging. The team members alerted each other to this. So, they could double check the product selected when dispensing. The team identified the importance of speaking to people about changes to the brand of medication. So, people didn't think they had been given the wrong medicine. The team sometimes completed monthly reviews of the errors. This helped to spot patterns and capture the actions taken to prevent the same error from happening again. A recent review highlighted the importance of using the Falsified Medicines Directive (FMD) scanning equipment to minimise picking errors. And that rushing to label and dispense prescriptions could impact on the accuracy of dispensing. This review also reminded the team members to not interrupt each other when dispensing. The pharmacy completed an annual patient safety report. The latest report included a reminder for the team to use tablet counters. And to double check the quantities counted out.

The pharmacy had a procedure for handling complaints raised by people using the pharmacy. And it had a leaflet providing people with information on how to raise a concern. The pharmacy team used surveys to find out what people thought about the pharmacy. The pharmacy published these on the NHS.uk website. And in the pharmacy retail area.

A sample of controlled drugs (CD) registers looked at found they met legal requirements. 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 the time the pharmacist signed out as the Responsible Pharmacist was often not recorded. Records of private prescription supplies looked at found that the prescriber's details were sometimes missing. 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 team had received training on the General Data Protection Regulations (GDPR). The pharmacy displayed details on the confidential data kept and how it complied with legal requirements. And it displayed a privacy notice in line with the requirements of the GDPR. The team separated confidential waste for shredding offsite.

The pharmacy team members had access to contact numbers for local safeguarding teams. The pharmacist had completed level 2 training in 2018 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 reported concerns to the team who shared them with the person's GP.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has a team with the qualifications and skills to support the pharmacy's services. The pharmacy offers team members opportunities to complete more training. And it provides feedback to team members on their performance. The pharmacy team members proactively share opinions on the delivery of pharmacy services. Which are followed up and acted upon.

Inspector's evidence

The pharmacist manager covered most of the opening hours. Locum pharmacists provided support when required. The pharmacy team consisted of two full-time qualified pharmacy technicians and delivery drivers. A company pharmacy technician provided holiday cover. The pharmacy provided extra training through e-learning modules. Recent topics included data protection. And pharmacy team members printed off training material for each other to access. The team had protected time to complete the training. The team members had shared their experience of the GPhC revalidation process. And they attended a local event about the different elements of revalidation.

The pharmacy technicians supported the wholesaling business. This took place at a recently de-registered part of the premises. But access was directly from the pharmacy. The team stated that this activity didn't impact on the delivery of pharmacy services.

The pharmacy provided performance reviews to the team. So, they had a chance to receive feedback and discuss development needs. The pharmacy technician who provided support to the Sexual Health services had asked for more involvement. And this had been agreed. The pharmacy technician was training the other pharmacy technician to provide this service. So, they could cover each other's holiday. Team members held meetings and they could suggest changes to processes or new ideas of working. The pharmacist manager had been asked to put a business plan together for new pharmacy services. This was for presenting to the company board. The pharmacist had not done anything like this before. And received support to complete this. The team worked together to prepare for the impact on workflow from implementing the Falsified Medicines Directive (FMD).

The pharmacy team took part in the company annual staff survey. Which the management team responded to. The last survey had highlighted the need to involve pharmacy teams with decisions. The company recent change of wholesaler had involved notification to the pharmacy teams of this. And an explanation of why this was happening. The company asked the pharmacy teams to respond to the proposal with any concerns they had. The pharmacy had targets for services such as Medicine Use Reviews (MURs). There was no pressure to achieve them. And 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. And it has good arrangements for people to have private conversations with the team.

Inspector's evidence

The pharmacy was clean, tidy and hygienic. It had separate sinks for the preparation of medicines and hand washing. 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 premises were secure. And the pharmacy had restricted access to the dispensary during the opening hours.

The pharmacy had a defined professional area. And items for sale in this area were healthcare related. The pharmacy had a large, sound proof consultation room. The company were planning a refit to increase the size of the consultation room to support the delivery of more pharmacy services.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides services that support people's health needs and manages its services well. The pharmacy keeps its records about prescription requests and deliveries up to date, so it can resolve any queries effectively. The pharmacy gets its medicines from reputable sources and generally stores and manages its medicines appropriately.

Inspector's evidence

People accessed the pharmacy via steps or a ramp, both with handrails. The pharmacy had an information leaflet to provide people with details of the services it offered and the contact details of the pharmacy. The window displays detailed the recent change to the opening times. The team had access to the internet to direct people to other healthcare services. And it kept a small range of healthcare information leaflets for people to read or take away. The pharmacy team offered people the opportunity to have their blood pressure checked. The pharmacy promoted this through the 'Do you know your BP' campaign. The team members had an eye-catching display to highlight the importance of having blood pressure checked. And they attached promotional stickers on bags containing dispensed medication. So, they could highlight the service to people collecting their medicines. 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 members could identify if they should refer the person 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 emergency hormonal contraception treatments and the smoking cessation medicine varenicline against patient group directions (PGDs). These gave the pharmacist the legal authority to supply these medicines. The pharmacy also provided a smoking cessation service for under 16-year olds. This was in partnership with local organisations who referred the young person to the service. One of the pharmacy technicians supported the teams at local sexual health clinics. The pharmacy technician checked the medicine stock levels and the medicine expiry dates. The pharmacy technician kept up to date with latest treatments. So, she could ensure the clinics had the correct stock levels of medicines to provide to people.

The pharmacy provided multi-compartmental compliance packs to help around 25 people take their medicines. And to people living in a care home. People received monthly or weekly supplies depending on their needs. One of the pharmacy technicians managed the service. And got support from others in the team. To manage the workload the team divided the preparation of the packs across the month. The team usually received 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 queried any changes with the GP team. The care home team ordered prescriptions two weeks before supply. And sent the pharmacy team information about the medicines ordered, any medicines in use but not ordered and the medication no longer in use. The team recorded the descriptions of the products within the packs. And supplied the manufacturer’s patient information leaflets. The pharmacy received copies of hospital discharge summaries. The team checked the discharge summary for changes or new items. The pharmacist was sometimes asked by the care home team for advice on medicines that were suitable for crushing. The pharmacist sent the care home team

a list of suitable medicines. And details of the reference sources the pharmacist had used to get this information.

The team members provided a repeat prescription ordering service. They used a system to remind them when they had to request the prescription. And they kept a record 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 regularly checked the system to identify missing prescriptions and chase them up with the GP teams. 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 team had completed checks to identify people that met the criteria of the valproate Pregnancy Prevention Programme (PPP). And found no-one who met the criteria. The pharmacy had the PPP pack to provide people with information when required.

The pharmacy used clear bags to hold dispensed controlled drugs (CDs) and fridge lines. This allowed the team, and the person collecting the medication, to check the supply. The pharmacy used CD and fridge stickers on bags and prescriptions to remind the team when handing over medication to include these items. The pharmacy had a system to prompt the team to check that supplies of 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.

The pharmacy team checked the expiry dates on stock. And it had a template to record this. But the team had not recently made any records. The last date check record was 12 March 2019. The team members used coloured dots to highlight medicines with a short expiry date. They used one dot for expiry dates less than six months. And they used two dots for stock with expiry dates less than 12 months. No out of date stock was found. The team members 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 furosemide 20mg/5ml with three months use once opened had a date of opening of 02 May 2019 recorded. The team usually recorded fridge temperatures each day. A sample looked at found that when the team recorded the fridge temperatures 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 equipment and a computer upgrade to meet the requirements of the Falsified Medicines Directive (FMD). The team were scanning most FMD compliant products. 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 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 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. The pharmacy had a fridge to store medicines kept at these temperatures. The fridge had a glass door to enable the team to view stock without prolong opening of the door. The team used a Rossmax machine when taking people’s blood pressure readings. The pharmacy completed safety checks on the electronic equipment.

The 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 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.