General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: York Pharmacy, 14-15 York Street, STOURPORT-ON-SEVERN, Worcestershire, DY13 9EF

Pharmacy reference: 1038885

Type of pharmacy: Community

Date of inspection: 24/07/2024

Pharmacy context

This is a community pharmacy in the centre of Stourport-on-Severn in Worcestershire. The pharmacy dispenses NHS and private prescriptions. It's team members sell a range of over-the-counter medicines and provide advice. The pharmacy offers the New Medicine Service (NMS), Pharmacy First and local deliveries. And it supplies some people's medicines inside multi-compartment compliance packs, if they find it difficult to take them.

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 is operating safely. It has appropriate systems in place to identify and manage the risks associated with its services. Team members regularly monitor the safety of the pharmacy's services. They record and learn from mistakes made during the dispensing process. The pharmacy suitably protects people's confidential information, and it maintains its records as it should.

Inspector's evidence

This was an organised pharmacy. The main members of the pharmacy team, including the owner had been absent for periods at a time and locum pharmacists were currently being used. Despite this, the pharmacy had continued to operate in an ordered way and in accordance with the standards set by the GPhC. The pharmacy had documented standard operating procedures (SOPs) to provide guidance on how to complete tasks appropriately. Staff had read and signed them, but a few versions of older SOPs were also present which could cause confusion for the team. Archiving them was advised during the inspection. The correct notice to identify the pharmacist responsible for the pharmacy's activities was on display. This provided details of the pharmacist in charge of the pharmacy's operational activities.

The pharmacy had processes in place for team members to safely dispense prescriptions and learn from mistakes. Staff were observed using prescriptions to select medicines against and generate dispensing labels. The dispensary was kept clear of clutter and an efficient workflow was in operation. People's prescriptions were prepared, assembled and accuracy-checked in separate areas of the dispensary. The team also prepared medicines for people requiring multi-compartment compliance packs in a separate area. In addition, before prescriptions were bagged and stored for collection, counter staff carried out a third-accuracy check. Dispensing staff recorded their own near miss mistakes, they were then collectively reviewed by the owner and any trends or patterns noted were shared during team meetings. Look-alike and sound-alike medicines, medicines that were commonly mistaken and higher-risk medicines, such as cytotoxics were highlighted and kept separate. The pharmacy had a complaints and incident handling process with details usually passed to the owner to manage. The responsible pharmacist's (RP) process was largely suitable with additional advice provided.

The pharmacy ensured people's confidential information was kept secure. Confidential waste was separated and removed for disposal. The pharmacy's computer systems were password protected and staff used their own individual NHS smart cards to access electronic prescriptions. No sensitive information could be seen from the retail area. The pharmacy's chaperone policy was on display. The RP had been trained to level three to safeguard the welfare of vulnerable people and staff also understood their responsibilities. They had access to contact details for the local safeguarding agencies.

The pharmacy's records were compliant with statutory and best practice requirements. This included a sample of registers seen for controlled drugs (CDs), the RP record, records of supplies made against private prescriptions, emergency supplies and unlicensed medicines. On randomly selecting CDs held in the cabinet, their quantities matched the stock balances recorded in the corresponding registers.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy’s services are delivered by team members who have a range of skills and experience. They understand their roles well. And they have access to resources so they can complete ongoing training. This helps keep their skills and knowledge up to date.

Inspector's evidence

Staff at the inspection included a pharmacy technician, a locum pharmacist, a pharmacy student, and a medicines counter assistant (MCA). The pharmacy's team members wore uniforms and their certificates to verify completed training were on display. The pharmacy technician was a very experienced and long-standing member of staff, she was observed to be competent and efficient in her role. Other staff also had the necessary knowledge to underpin their activities, they were observed to work well together and the pharmacy was up to date with the workload. The MCA was enrolled onto accredited training in accordance with her role. The team knew which activities could take place in the absence of the RP and referred appropriately. Relevant questions were asked before selling medicines and medicines which could be abused were monitored. Members of the pharmacy team had regular and formal appraisals with the owner. They described him being fair, supportive and a good manager. Staff also had access to resources for ongoing training and communicated verbally with regular discussions and team meetings.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are a suitable environment to deliver healthcare services from. The pharmacy is kept clean. And it has a separate space where confidential conversations or services can take place.

Inspector's evidence

The pharmacy premises were professional in appearance, maintained well, and kept clean. The pharmacy consisted of a larger retail area, an adequately sized dispensary, staff areas to one side and a stock room at the very rear. The dispensary had adequate space to safely prepare, process and store prescriptions as well as medicines. There was also a consultation room in the retail area for private conversations and services. This room was large, signposted, and soundproof. It was kept locked when not in use and was suitable for its intended purpose. The premises were sufficiently bright and appropriately ventilated, with air conditioning and heaters if needed. The pharmacy's premises were generally kept tidy. The dispensary and retail area were very smart. However, the stock room was quite cluttered at the point of inspection and the consultation room could have been tidier.

Principle 4 - Services ✔ Standards met

Summary findings

Overall, the pharmacy provides its services appropriately and efficiently. People receive their medicines inside compliance packs safely. Members of the pharmacy team regularly identify people receiving higher-risk medicines and carry out appropriate checks. This helps ensure they are suitably advised about their medicines. The pharmacy sources its medicines from reputable suppliers and stores its medicines well. The pharmacy also has some checks in place to ensure that medicines are not supplied beyond their expiry date. But necessary records to help verify this are missing.

Inspector's evidence

The pharmacy's opening times were clearly advertised, and the pharmacy had several leaflets on display to provide information about various health matters. People could enter the pharmacy from the front door which had a step. Staff explained that they monitored and assisted people with wheelchairs at the door. Staff described making reasonable adjustments for some people with different needs if this was required. This included providing people with written details, communicating verbally to people who were visually impaired, speaking slowly, loudly if possible or using the consultation room if needed.

The team used baskets to hold prescriptions and medicines during the dispensing process. This helped prevent any inadvertent transfer. The baskets were also colour coded which helped identify priority and different workstreams. Once staff generated the dispensing labels, there was a facility on them to help identify who had been involved in the dispensing process. Team members routinely used these as an audit trail. Staff were aware of the additional guidance when dispensing sodium valproate and the associated Pregnancy Prevention Programme (PPP). They ensured the relevant warning details on the packaging of these medicines were not covered when they placed the dispensing label on them, and only provided full packs. They had also identified people in the at-risk group who had been supplied this medicine, ensured people were counselled appropriately and supplied relevant educational material. In addition, the team routinely identified people with other higher-risk medicines, they asked relevant questions about blood test results and recorded this information.

The pharmacy supplied some people's medicines inside multi-compartment compliance packs once the person's GP had identified a need for this. The pharmacy ordered prescriptions on behalf of people for this service and specific records were kept for this purpose. Any queries were checked with the prescriber and the records were updated accordingly. All medicines were removed from their packaging before being placed inside them. Descriptions of the medicines inside the compliance packs were provided and patient information leaflets (PILs) were supplied. The pharmacy provided local deliveries and the team kept records about this service. CDs and fridge items were highlighted. Failed deliveries were brought back to the pharmacy, notes were left to inform people about the attempt made and no medicines were left unattended.

The pharmacy used licensed wholesalers to obtain medicines and medical devices. Medicines were stored in a very organised way. CDs were stored securely and the keys to the cabinet were maintained in a way which prevented unauthorised access. Medicines which were returned to the pharmacy by people for disposal, were accepted by staff, and stored within designated containers or bags. This included sharps provided they were within appropriate containers. Drug alerts were received through

wholesalers and electronically. Staff explained the action the pharmacy took in response and relevant records were kept verifying this. Team members said that medicines were date-checked for expiry regularly, but appropriate records had not been kept verifying when this had taken place. This made it difficult for them to show that this process had been routinely occurring. However, short-dated medicines were seen to be identified and there were no date-expired medicines seen. Staff also checked the expiry date upon receipt from wholesalers and during the dispensing process.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the necessary equipment and facilities it needs to provide its services safely. And its equipment ensures people's private information is secure.

Inspector's evidence

The pharmacy had access to the necessary equipment and resources in line with its activity. This included internet access, standardised conical measures for liquids, tablet counting triangles and capsule counters, a clean dispensary sink, which had hot and cold running water as well as hand wash. There were also legally compliant CD cabinets. The computer terminal was password protected. Additional equipment for the pharmacy's services included an otoscope, tongue depressors, a torch and a thermometer which were new as well as a relatively new blood pressure machine. Portable telephones helped conversations to take place in private if required. The pharmacy's computer terminals were password protected and their screens faced away from people using the pharmacy.

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.