General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Pickering Pharmacy, 22 Market Place, PICKERING, North Yorkshire, YO18 7AE

Pharmacy reference: 1038963

Type of pharmacy: Community

Date of inspection: 04/09/2024

Pharmacy context

The pharmacy is on a high street in the centre of Pickering. And is open seven days a week. Pharmacy team members dispense NHS prescriptions and sell a range of over-the-counter medicines. The pharmacy provides services, such as the NHS Pharmacy First service and seasonal flu vaccinations. Team members provide medicines to people in multi-compartment compliance packs. And they deliver medicines to people's homes.

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 adequately identifies and manages risks. Pharmacy team members understand their role to help protect vulnerable people. And they suitably protect people's confidential information. The pharmacy has most of the written procedures it needs relevant to its services to help team members provide services safely. Team members record their mistakes so that they can learn from them. But they don't always capture key information or regularly analyse their mistakes to identify patterns. So, they may miss some opportunities to learn and improve.

Inspector's evidence

The pharmacy had a set of standard operating procedures (SOPs) in place to help pharmacy team members manage risks. The responsible pharmacist (RP) and pharmacy technician manager reviewed the SOPs when there was a significant change to the pharmacy's processes. And in response to a patient safety incident. One example of this had been a recent change to the pharmacy's process for preparing and dispensing prescriptions for controlled drugs (CDs) following an error. But they otherwise did not regularly review the SOPs. Some SOPs were due for review at various times between 2017 and 2023 and had not been completed. This meant they may not reflect the pharmacy's current practice. Pharmacy team members had signed to confirm they had read and understood the SOPs. But they were only required to read the SOPs when they first started working at the pharmacy. Or after they had been reviewed and changed. And this meant team members may not always be clear about their responsibilities.

The pharmacy provided the NHS Pharmacy First service to people. Pharmacy team members explained how the pharmacy had considered some of the risks of providing the service, such as the suitability of the pharmacy's consultation room to deliver the service from. And ensuring they had completed the necessary training and whether the pharmacy had the correct SOPs and supporting documents in place. The pharmacy displayed posters in the retail area explaining the service to people. These included information about each condition and how the pharmacy could help. Team members had created a document for them to refer to, which highlighted the key inclusion criteria for each condition covered by the service. They used the document as an aide memoire to help them appropriately refer people to the pharmacist for a consultation.

Pharmacy team members highlighted and recorded errors identified before people received their medicines, known as near miss errors. And dispensing errors, which were errors identified after the person had received their medicines. There were documented procedures to help them do this effectively. They discussed their errors and why they might have happened. And they gave some examples of changes they had made to help prevent isolated near miss errors from happening again. Team members did not record information about why the mistakes had been made or the changes they had made to prevent a recurrence to help aid future reflection and learning. The RP and manager analysed the data approximately yearly to establish any patterns of mistakes. And they explained how they discussed any patterns they noticed more frequently with the team, although more frequent analyses were not recorded. This meant team members may miss opportunities to reflect and establish whether their changes had been effective. Pharmacy team members gave a clear explanation of how they would handle and record a dispensing error. And how they reported these errors to the superintendent pharmacist (SI). Examples of their records were available which provided some

information about the errors. But again, team members did not capture much information about causes and the actions they had taken in response to each error to help aid future reflection and learning.

The pharmacy had a documented procedure for handling complaints and feedback from people. Pharmacy team members explained people usually provided verbal feedback. And any complaints were referred to the pharmacist or manager to handle. There was information available for people in the retail area about how to provide the pharmacy with feedback.

The pharmacy had current professional indemnity insurance in place. The pharmacy kept accurate CD registers. It kept running balances for all registers. Pharmacy team members audited most of these balances each month. Checks of the running balances against the physical stock for three products were found to be correct. The pharmacy kept a register of CDs returned by people for destruction. It maintained a responsible pharmacist record electronically. The record was up to date but had several gaps in the sign-out time of the RP. The pharmacist displayed their responsible pharmacist notice. The pharmacy kept private prescription and emergency supply records, which were complete and in order.

The pharmacy kept sensitive information and materials in restricted areas. Team members shredded confidential waste. The pharmacy had a documented procedure and a file of information in place to help pharmacy team members manage sensitive information. Pharmacy team members explained how important it was to protect people's privacy and how they would protect confidentiality.

Pharmacy team members gave some examples of signs that would raise their concerns about vulnerable children and adults. And how they would discuss their concerns with the pharmacist and superintendent pharmacist (SI) if necessary. They were also aware of how to find information about key local safeguarding contacts by using the internet. Team members were unable to find the pharmacy’s safeguarding procedure during the inspection. They had recently completed safeguarding training.

Principle 2 - Staffing ✔ Standards met

Summary findings

Pharmacy team members have the right qualifications and skills for their roles and the services they provide. They complete training to help keep their knowledge and skills up to date. Team members feel comfortable raising concerns and discussing ways to improve services.

Inspector's evidence

At the time of the inspection, the pharmacy team members present were a pharmacist, a pharmacy technician, two qualified dispensers, a trainee dispenser, a medicines counter assistant, two trainee medicines counter assistants, a delivery driver and a trainee dispenser. Team members completed training modules ad hoc to keep their knowledge and skills up to date. The most recent examples of completed training included learning about domestic abuse. Team members also explained how they had regular discussions with the pharmacists and other colleagues. The pharmacy employed three other pharmacists. And on weekdays, the pharmacists organised their working patterns to overlap, which allowed them to work together for at least half a day. This provided regular opportunities for one pharmacist to focus on delivering services to people, while the other concentrated on managing and providing people's prescriptions.

Pharmacy team members explained how they would raise professional concerns with the pharmacist, pharmacy manager, or SI. They felt comfortable sharing ideas to improve the pharmacy or raising a concern. And they were confident that their concerns would be considered, and changes would be made where they were needed. The pharmacy had a formal whistleblowing policy. Team members were unsure about how to access the process. But they were aware of how they could raise concerns with the GPhC or the NHS.

Team members explained how they communicated well with each other to manage their workload. And this open dialogue was seen during the inspection. Team members felt comfortable making suggestions to improve their ways of working. They explained how they had recently changed the way they managed prescriptions where medicines were owed to people. And how they had changed the way they dispensed and prepared prescriptions for insulin to help identify any mistakes before they were handed out to people. The pharmacy did not ask team members to achieve any specific performance-related targets.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean and properly maintained. It provides a suitable space for the services it provides. The pharmacy has a consultation room where people can speak to pharmacy team members privately.

Inspector's evidence

The pharmacy was clean and well maintained. It was tidy and generally well organised. The pharmacy's floors and passageways were free from clutter and obstruction. It kept equipment and stock on shelves throughout the premises. And it had a private consultation room. Pharmacy team members used the room to have private conversations with people.

The pharmacy had a clean, well-maintained sink in the dispensary used for medicines preparation. It had a toilet, with a sink which provided hot and cold running water and other facilities for hand washing. The pharmacy maintained its heating and lighting to acceptable levels. The pharmacy's overall appearance was professional, including the pharmacy's exterior which portrayed a healthcare setting. The pharmacy's professional areas were well defined by the layout and were signposted from the retail area. Pharmacy team members prevented access to the restricted areas of the pharmacy.

Principle 4 - Services ✔ Standards met

Summary findings

Pharmacy team members manage and provide the pharmacy's services safely and effectively. The pharmacy suitably sources its medicines. It stores and manages its medicines appropriately. And it has some processes to help people understand and manage the risks of taking higher-risk medicines. But team members don't always provide people with the necessary printed information to help them manage taking their medicines properly.

Inspector's evidence

The pharmacy had level access from the street. Pharmacy team members could use the electronic patient medication record (PMR) system to produce large-print labels to help people with visual impairment take their medicines properly. And they gave examples of how they used written communication to help people with hearing impairment access their services and use their medicines safely.

The pharmacy used robotic technology in the dispensing process to help speed up the process and reduce the risk of selection errors. Some medicines were unable to be stored in the robot, so the pharmacy stored these items on shelves around the pharmacy. Pharmacy team members regularly checked the use of stock stored in the robot to determine if they were using the system most effectively. This also helped them to identify and remove medicines that may be nearing their expiry. Pharmacy team members clearly explained how they also used the PMR barcode scanning technology to help reduce errors for medicines that were not stored in the robot. They demonstrated how they picked medicines from the shelves and scanned the barcodes on the packs. The system blocked any further progression of the prescription through the system if a team member scanned the incorrect medicine. They were unable to proceed until they scanned the correct product. But team members did not always use barcode scanning when dispensing this way. And they sometimes inputted information into the PMR system manually. This meant they were not always using the available technology to help reduce the risks of mistakes.

The pharmacist counselled people receiving prescriptions for valproate if appropriate. And they checked if the person was aware of the risks if they became pregnant while taking the medicine. They also checked if the person was on a Pregnancy Prevention Programme. The pharmacy had recently completed an audit of patients who received valproate from the pharmacy, to help make sure they had received the necessary guidance and information. Team members were aware of the requirements to provide valproate to people in the manufacturer's original packaging.

The pharmacy supplied medicines to people in multi-compartment compliance packs when requested, to help people use their medicines safely. A significant proportion of these packs were prepared using robotic dispensing technology at another pharmacy owned by the same company. The pharmacy attached backing sheets to the packs, so people had written instructions of how to take their medicines. Pharmacy team members included descriptions on the backing sheets of what the medicines looked like, so they could be identified in the pack. But they did not routinely provide people with patient information leaflets about their medicines each month. Team members documented any changes to medicines provided in packs on the PMR, and on the person's master record sheet which kept a record of all their medicines and where they were placed in the packs. The pharmacy had obtained verbal

consent from people to have their packs prepared elsewhere, but it had not recorded the consent given. Team members had discussed with people whether the pack system being used was suitable for them. And they had included others involved with the person's care in these discussions, such as their GP and carers.

The pharmacy obtained medicines from licensed wholesalers. It had disposal facilities available for unwanted medicines, including CDs. Team members monitored the minimum and maximum temperatures in the pharmacy's fridges each day and recorded their findings. The temperature records were within acceptable limits. Pharmacy team members checked medicine expiry dates every month. But they did not always record their checks. Team members gave their assurances that regular checks were completed. Team members highlighted any short-dated items up to six months before their expiry. And removed items in the month before they were due to expire. After a search of the shelves, the inspector did not find any medicines that were out of date. Pharmacy team members responded to manufacturers alerts and recalls. They kept records of the recalls they had received and any action they had taken to remove affected medicines. The pharmacy delivered some medicines to people. But it did not record the deliveries it made to help easily manage future queries. The delivery driver left a card through the letterbox if someone was not at home when they attempted delivery for a second time. The card asked people to contact the pharmacy.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide its services safely. It maintains its equipment properly, so it is safe to use. And pharmacy team members manage and use the equipment in ways that protect people’s confidentiality.

Inspector's evidence

The pharmacy had the equipment it needed to provide the services offered. It also had various reference resources available and use of the internet. The pharmacy had a set of clean, well-maintained measures available to help prepare liquid medicines. It had suitable equipment available to destroy its confidential waste. And it kept its password-protected computer terminals and bags of medicines waiting to be collected in the secure areas of the pharmacy, away from public view and where people's private information was protected. The pharmacy’s dispensing robot was serviced each year. If the machine broke down, team members were able to contact a service engineer. The engineer provided remote support to help fix most issues. And were also available to provide on-site support, usually within 12 hours.

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.