

# Registered pharmacy inspection report

**Pharmacy Name:** ARC Pharmacy, Portholme Road, SELBY, North Yorkshire, YO8 4QH

**Pharmacy reference:** 1038999

**Type of pharmacy:** Community

**Date of inspection:** 04/12/2019

## Pharmacy context

This community pharmacy is within a GP surgery in the centre of Selby. The pharmacy dispenses NHS and private prescriptions. The pharmacy supplies multi-compartment compliance packs to help people take their medicines. And it delivers medication to people's homes. The pharmacy provides the flu vaccination service. The pharmacy provides the supervised methadone consumption service. And it provides a needle exchange 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
<b>1. Governance</b>	Standards met	N/A	N/A	N/A
<b>2. Staff</b>	Standards met	N/A	N/A	N/A
<b>3. Premises</b>	Standards met	N/A	N/A	N/A
<b>4. Services, including medicines management</b>	Standards met	N/A	N/A	N/A
<b>5. Equipment and facilities</b>	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. And it keeps the records it needs to by law. The pharmacy has arrangements to protect people's private information. People using the pharmacy can raise concerns and provide feedback. The team members have some level of training, guidance and experience to respond to safeguarding concerns. So, they can help protect the welfare of children and vulnerable adults. The pharmacy team members respond appropriately when errors happen. They take the action needed to help prevent similar mistakes happening again. But they don't fully record all their errors. So, the team does not have all the information available to help identify patterns and reduce mistakes.

### Inspector's evidence

The pharmacy had a range of up-to-date standard operating procedures (SOPs). These provided the team with information to perform tasks supporting the delivery of services. The SOPs were divided into sections reflecting the GPhC standards for registered pharmacies. The SOPs covered areas such as dispensing prescriptions and controlled drugs (CDs) management. The team had read the SOPs 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 near miss errors. The pharmacy had been using a form that combined near miss errors and dispensing incidents. Now the pharmacist asked team members to write their near miss errors on post-it notes. The Superintendent Pharmacist collected these notes and reviewed them each month. This ran the risk of losing the notes and the information gathered. And did not provide the team members with an opportunity to record what caused the error, their learning from it and actions they had taken to prevent the error happening again. A sample of near miss records from the form previously used showed details of what had been prescribed and dispensed to spot patterns. But team members had not recorded any other information such as the cause of the error and what they had done to prevent the same mistake. The team discussed common errors and had separated prednisolone and propranolol after identifying they were often involved with picking errors. The pharmacy team recorded dispensing incidents. These were errors identified after the person had received their medicines. One report recorded a delivery error caused by the team attaching an incorrect name and address label to the bag. After this the team members were asked to focus when attaching bag labels. And to triple check that they had attached the correct bag label.

The pharmacy completed an annual patient safety report. The latest report stated that the team introduced a triple check for schedule three CDs as well as schedule two CDs. One team member dispensed the CD and a second team member checked the CD picked before the pharmacist completed the final check. Each team member involved in the triple check initialled the dispensing label to show this had been done. The report highlighted that team members were reminded to check a person's date of birth when dispensing several prescriptions. So, they could ensure they had the same person each time, especially for people with similar names. But the team members did not use the electronic patient medication record (PMR) to highlight people with similar names to prompt them to check the date of birth.

The pharmacy had a procedure for handling complaints raised by people using the pharmacy. And it had a poster 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 for people to refer to. Positive comments included a polite team who took time to listen.

A sample of controlled drugs (CD) registers looked at found that 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 that they met legal requirements. Records of private prescription supplies, and emergency supply requests met legal requirements. 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). And the pharmacy had a SOP covering confidentiality. The pharmacy had an information governance (IG) folder containing several IG documents including confidentiality agreements signed by the pharmacy team. 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 had safeguarding guidance for the team members to refer to. And the team members had signed the guidance to show they had read it. The team members had access to contact numbers for local safeguarding teams. The pharmacist and pharmacy technicians had completed level 2 training from the Centre for Pharmacy Postgraduate Education (CPPE) on protecting children and vulnerable adults. The team had completed Dementia Friends training. The team responded well when safeguarding concerns arose. The delivery driver reported to the pharmacy team any concerns they had about people they delivered to. The team shared these concerns 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 team members support each other in their day-to-day work. They identify improvements to the delivery of pharmacy services. And they update their processes especially after dispensing errors happen to improve their efficiency and safety in the way they work. The pharmacy gives team members regular feedback on their performance. So, they can take opportunities to develop and keep their skills up to date. But it doesn't provide its team members with regular ongoing training to support keeping their continual knowledge up to date.

### Inspector's evidence

The Superintendent Pharmacist and a regular pharmacist covered the opening hours. And the two worked together three days a week. The pharmacy team consisted of four part-time pharmacy technicians, three who were accuracy checking technicians (ACT), four part-time dispensers, one part-time trainee dispenser, two part-time medicines counter assistants (MCA) and a delivery driver. At the time of the inspection the Superintendent Pharmacist, three pharmacy technicians, four dispensers and two MCAs were on duty. The pharmacy provided new starters with an induction programme. But it did not provide extra training to the team members once they were qualified.

The pharmacy team worked well together. Team members supported each other when workload increased. And gave each other feedback on jobs well done. The pharmacy provided performance reviews for the team. So, they had a chance to receive feedback and discuss development needs. The team members could suggest changes to processes or systems such as rearranging the storage shelves to help them easily locate stock. The pharmacy had a whistleblowing policy that all the team had read and signed. The pharmacy did not have targets for the services provided. The pharmacy team 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 facilities to meet the needs of people requiring privacy when using the pharmacy services.

### Inspector's evidence

The dispensary was small with limited work space. The team managed this by keeping work benches free of clutter. 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 a large, sound proof consultation room. The team used this for private conversations with people. And a section of the pharmacy counter was sectioned off to also allow private conversations to take place. The premises were secure. The pharmacy had restricted access to the dispensary during the opening hours. The window displays detailed the opening times and the services offered. The pharmacy had a defined professional area. And items for sale in this area were healthcare related.

## Principle 4 - Services ✓ Standards met

### Summary findings

The pharmacy team provides services that support people's health needs. And it manages its services well. The team members clearly highlight medicines awaiting collection. So, they can undertake appropriate checks and provide suitable advice to the person collecting their medicines. The pharmacy team members keep records of deliveries they make to people. So, they can deal with any queries effectively. The pharmacy obtains its medicines from reputable sources. And it stores and manages medicines appropriately.

### Inspector's evidence

People accessed the pharmacy via a step free entrance. The team had access to the internet to direct people to other healthcare services. The pharmacy kept a small range of healthcare information leaflets for people to read or take away. The pharmacy had a monthly healthcare leaflet providing people with information on a medical condition and pharmacy services. The leaflet included a quiz to test the person's knowledge on the information provided. Recent topics included asthma, inhaler technique and the pharmacy minor ailments scheme. The leaflet also included the pharmacy opening hours and contact details. The pharmacy provided the flu vaccination service against up-to-date patient group directions (PGDs). These provided the pharmacists with the legal authority to administer the flu vaccination.

The pharmacy provided multi-compartment compliance packs to help several people take their medicines. The service included people who lived in a care home. People received monthly or weekly supplies depending on their needs. Two members of the dispensary team 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 ordered prescriptions in advance 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 medication record listing their current medication and dose times. The team checked received prescriptions against the list. And queried any changes with the GP team. The team used an upstairs room to dispense the medication and check the packs. This was away from the distractions of the busy dispensary and retail area. The team recorded the descriptions of the products within the packs. But a sample of packs looked at found the descriptions were limited to tablets or capsules. The team 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 pharmacy supplied methadone as supervised and unsupervised doses. And it prepared the methadone doses in advance before supply. This reduced the workload pressure of dispensing at the time of supply. The pharmacy stored the prepared doses in the controlled drugs cabinet in rows. But there was no physical divide between the rows to help prevent the wrong dose being picked. The pharmacist performed a second check of the methadone dose before handing it to the person. The pharmacist invited the person into the consultation room to take their dose. The needle exchange service involved people placing the used needle containers directly into a dedicated waste bin. The bin was beneath the pharmacy counter and accessed by sliding open a hole in the counter. So, the team had no direct contact with the containers.

The pharmacy provided separate areas for labelling, dispensing and checking of prescriptions. The ACTs

used a small section of the main dispensary to check 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. The team members used this as a prompt to check what they had picked. 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. The dispensers checked their own work before initialling the dispensed by box and passing it to the pharmacist to check. The dispensers marked information on the packaging such as quantity and strength as they checked the dispensed medicine against the prescription. The pharmacy team used a stamp to record the pharmacist's clinical check of the prescription. So, the ACTs could perform their accuracy check. 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 team separated prescriptions with owings or incomplete prescriptions so they could prioritise the dispensing of these medicines when the stock arrived. The pharmacy kept a record of the delivery of medicines to people. This included a signature from the person receiving the medication.

The pharmacy team was aware of the criteria of the valproate Pregnancy Prevention Programme (PPP). The pharmacy had the PPP pack to provide people with information when required. The team members marked the label attached to the bags holding completed prescriptions awaiting collection to prompt them to ask certain questions. For example, D was used to remind the team to ask people prescribed diabetic medicines if they'd had a foot or eye check in the last 12 months. And P reminded the team that pregabalin was now a CD and the person had to sign the back of the prescription. The pharmacy also 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 team checked the expiry dates on stock. And it kept a record of this. The last date check was in November 2019. The team used coloured dots to highlight medicines with a short expiry date. And it kept a list of products due to expire each month. 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 dexamethasone oral solution with three months use once opened had a date of opening of 11 November 2019 recorded. The team recorded fridge temperatures each day. A sample looked at found 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 to meet the requirements of the Falsified Medicines Directive (FMD). And the team was using the equipment. 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 Superintendent Pharmacist also received the alert on their mobile phone. 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. And used separate, marked measures for methadone. The pharmacy had three fridges to store medicines kept at these temperatures. The team used one fridge for completed prescriptions awaiting supply to the person. And used the other fridges for stock. The pharmacy completed safety checks on the electrical 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.