General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Tadcaster Pharmacy, 7-9 High Street, TADCASTER, North Yorkshire, LS24 9AP

Pharmacy reference: 1039012

Type of pharmacy: Community

Date of inspection: 09/09/2024

Pharmacy context

This pharmacy is on a high street in Tadcaster town centre. 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 also dispense these packs for four of the company's other pharmacies. They deliver medicines to people's homes.

Overall inspection outcome

Standards not all met

Required Action: Improvement Action Plan

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 not all met	1.1	Standard not met	The pharmacy doesn't adequately manage all the risks associated with its services. Pharmacy team members don't have access to up-to-date SOPs that reflect the pharmacy's current practice and available technology. And they do not read the SOPs that are available to help them complete tasks safely and effectively.
		1.7	Standard not met	The pharmacy does not adequately identify and destroy confidential waste, which increases the risk of it being disposed of inappropriately.
2. Staff	Standards met	N/A	N/A	N/A
3. Premises	Standards not all met	3.1	Standard not met	The pharmacy does not store unused chemicals appropriately. This presents a significant unmanaged health and safety risk to pharmacy team members.
4. Services, including medicines management	Standards not all met	4.3	Standard not met	The pharmacy does not have effective processes for properly monitoring medicines stored in the fridge. This increases the risk of supplying medicines to people that are not fit to use. And it does not always provide people with enough printed information to help them manage taking their medicines safely.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance **Standards not all met**

Summary findings

The pharmacy doesn't adequately identify and manage all the risks associated with its services. It has some written procedures to help pharmacy team members manage these risks. But these are out-of-date. And they do not include procedures to help manage the pharmacy's automated dispensing systems. So, they may not understand the correct way to use the automated systems effectively. Most pharmacy team members do not read the available procedures which means they may not fully understand the correct processes to follow. The pharmacy does not suitably identify and destroy confidential waste, which increases the risk of sensitive information being disposed of inappropriately. Pharmacy team members understand their role to help protect vulnerable people. They record and discuss the mistakes they make so that they can learn from them. And they generally keep other necessary records.

Inspector's evidence

The pharmacy had a set of standard operating procedures (SOPs) to help pharmacy team members manage some risks. The responsible pharmacist (RP) was responsible for reviewing the SOPs. They usually did this 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 recent changes and updates to the pharmacy's process for managing confidential information. But they otherwise did not regularly review the SOPs. They explained this was because of current workforce pressures. Most SOPs were due for review in 2018, but this had not been completed. This meant there were several SOPs that did not reflect the pharmacy's current practice. For example, the SOP for dispensing prescriptions did not include information about how team members should use the pharmacy's available technology. Some pharmacy team members had signed to confirm they had read and understood the SOPs. But most of the signatures belonged to team members that no longer worked at the pharmacy. There were several new team members who had read the SOPs but not signed to confirm their understanding. And some team members had not read the SOPs. This meant team members may not always be clear about their responsibilities. There were also no SOPs in place to help manage the risks of some of the pharmacy's key processes, such as using the various robotic dispensing technology while dispensing and providing multi-compartment compliance packs for the company's four other pharmacies. Team members explained they asked the pharmacist or more experienced colleagues if they were unsure about how to complete a task.

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 had the correct SOPs and supporting documents in place. 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. When people requested the service team members gave them a questionnaire to complete. It asked them various questions about their symptoms and why they had come to the pharmacy. The pharmacist then used the information to help inform their consultations with people.

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. One example was separating look-alike and sound-alike medicines when unpacking medicines orders to help prevent them being placed in the wrong area in the pharmacy's automated robotic dispensing system. Team members did not record information about why the mistakes had been made or the changes they had made to prevent a reoccurrence to help aid future reflection and learning. The RP analysed the data approximately every three months to establish any patterns of mistakes. And they explained how they discussed any patterns they noticed with the team. Pharmacy team members gave a clear explanation of how they would handle and record a dispensing error. They reported these errors to the superintendent pharmacist (SI). Examples of their records were available which provided some information about the errors. But, 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. The pharmacy did not have any information available for people in the retail area about how to provide the pharmacy with feedback. So, they may not be aware of how to raise a concern or provide feedback.

The pharmacy had current professional indemnity insurance in place. The pharmacy kept accurate controlled drug (CD) registers, along with running balances for all registers. But team members did not regularly audit these balances which meant they may not identify discrepancies in a timely way. 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, which meant the record was not a completely accurate reflection of which pharmacist was responsible at all times. The pharmacist displayed their responsible pharmacist notice to people. The pharmacy kept private prescription and emergency supply records, which were complete and in order.

Pharmacy team members collected confidential waste in plastic bags. These bags were then stored in a room on the first floor of the pharmacy. Team members explained that the superintendent pharmacist (SI) usually arranged for the bags to be collected and taken for secure destruction. But this had not happened for some time. And there was a significant accumulation of confidential waste that had not been taken for proper destruction. The bags had not been marked as confidential waste. So, there was an increased risk that these bags could be confused for general waste and disposed of inappropriately. The pharmacy kept sensitive information and materials in restricted areas. A documented procedure and a file of information was 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 discussed 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. There was an SOP to help them do this effectively. And team members had recently completed safeguarding training.

Principle 2 - Staffing ✔ Standards met

Summary findings

Pharmacy team members have the right qualifications and skills, or are enrolled on appropriate training courses, 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 discuss ways to improve services.

Inspector's evidence

At the time of the inspection, the pharmacy team members present were a pharmacist, a pharmacy technician, a qualified dispenser, a trainee dispenser, two medicines counter assistants, and a trainee medicines counter assistant. Team members completed training modules ad hoc to keep their knowledge and skills up to date. They also explained how they had regular discussions with the pharmacists and other colleagues. The pharmacy did not have a formal appraisal process for team members. They explained how they would raise any learning needs informally with the pharmacist.

Pharmacy team members explained how they would raise professional concerns with the pharmacist 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 knew how to access the process. And 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 stored large prescriptions with several items to help make them easier to find, and to help prevent delays when people collected their prescriptions. The pharmacy did not ask team members to achieve any specific performance-related targets.

Principle 3 - Premises **Standards not all met**

Summary findings

The pharmacy stores unused chemicals in a way which poses a significant hazard and risk to pharmacy team members. The pharmacy is clean. And its other areas are generally tidy 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 spread over two floors. Team members used the space on the first floor to house the pharmacy's robotic dispensing equipment, to prepare multi-compartment compliance packs using different robotic dispensing technology, and for storage.

In a room on the first floor, the pharmacy stored a significant quantity of old bottles of medicines and chemicals which had never been used. Team members explained they had been there for years and had been inherited from the pharmacy's previous owner. Some of the bottles contained chemicals that were toxic. The shelves where the bottles were stored lined the wall of the room. And some bags of confidential waste were stored against the bottles on the shelves, which increased the risk of bottles breaking. This presented a significant health and safety risk to pharmacy team members, particularly if any bottles were damaged or broken.

The pharmacy was clean and well maintained. It was generally tidy and well organised. But there were other areas on the first floor that were untidy, with some benches cluttered with stock and dispensing baskets in the room where team members prepared multi-compartment compliance packs. The pharmacy's floors and passageways were generally free from clutter and obstruction. It kept stock in the robotic dispensing systems and 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 to prepare medicines before they were supplied to people. 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.

Principle 4 - Services **Standards not all met**

Summary findings

The pharmacy does not adequately monitor fridge temperatures. This means it may not be able to demonstrate that it appropriately stores medicines at the correct temperature so they remain safe to use. The pharmacy has processes in place to help people understand the risks of taking some higher-risk medicines. But it does not provide people receiving medicines in multi-compartment compliance packs with enough information to help them use their medicines safely. The pharmacy's services are easy for people to access. And it suitably sources its medicines.

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 automation for dispensing multi-compartment compliance packs into pouches. And it acted as a hub to dispense these packs for the other four spoke pharmacies in the same company. Two pharmacy team members who usually managed the system and pack preparation were not available to speak to during the inspection. And the other team members available had a limited understanding of how the automated system operated. There was no SOP in place to help team members manage the risks of using automated dispensing technology to prepare packs. And there were no written procedures to help manage the risks of the pharmacy acting as a hub to dispense for the company's other pharmacies. This meant that team members may not be clear about how to effectively manage these risks. And they may not understand who was responsible for key stages of the dispensing process.

Team members clearly explained their process for receiving prescriptions for packs from their spoke pharmacies. Prescriptions were checked for clinical and technical accuracy by team members at the spoke pharmacy before the prescription was sent to the hub to be assembled and dispensed. Team members transferred medicines from original manufacturer's packaging into canisters for dispensing and these were loaded into the system for the production of the pouches. The base of the canister was a unique shape and contained a unique barcode. This meant it could only be placed in the system in one location. Team members scanned barcodes, including the barcodes on packs of medicines and stock containers to help prevent mistakes. Not all medicines were dispensed from the canisters. Pharmacy team members manually added some medicines to the system to be dispensed into pouches. After the medicines were dispensed into pouches, the pharmacy used photographic identification technology to scan the medicines in each pouch. The pharmacist completed a visual check of any pouch that the system highlighted as having a potential inaccuracy or anomaly. And they visually checked one pouch from every pack dispensed. Each pouch displayed printed information about its contents, including the name and quantity of each medicine, the day, date, and time the medicines should be taken, along with the person's details. Once completed, team members transferred a person's pouches into a box. And the boxes were returned to the spoke pharmacy to provide to people. The pharmacy did not attach any descriptions of what the medicines looked like, so they could be identified in the pack. And they did not provide people with patient information leaflets about their medicines regularly, which meant people may not have easy access to information about their medicines.

The pharmacy had two fridges which it used to store medicines. Pharmacy team members did not regularly monitor or record the temperatures in the fridges to help determine if they stored medicines at the correct temperature range of between two and eight degrees Celsius. During the inspection, one of the fridges thermometers was showing a maximum of 13.4 degrees. And the other displayed a maximum of 15.3 degrees and a minimum of zero degrees. Team members did not know when the fridges had deviated from the permitted safe temperatures range, or for how long.

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 and in drawers 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 electronic patient medication record (PMR) system's barcode scanning technology to help reduce errors for higher-risk medicines that were not stored in the robot, such as insulin and controlled drugs. 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.

Pharmacy team members signed the 'dispensed-by' and 'checked-by' boxes on dispensing labels during dispensing. This maintained an audit trail of the people involved in the dispensing process. They used baskets throughout the dispensing process to help prevent prescriptions being mixed up. The pharmacy delivered medicines to some people. It recorded the deliveries it made. The delivery driver left a card through the letterbox if someone was not at home when they attempted delivery. The card asked people to contact the pharmacy.

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. Team members were aware of the requirements to provide valproate to people in the manufacturer’s original packaging.

The pharmacy obtained medicines from licensed wholesalers. It had disposal facilities available for unwanted medicines, including CDs. Pharmacy team members checked medicine expiry dates every month. But they did not record their checks, so some medicines may be overlooked. Team members gave their assurances that regular checks were completed. They highlighted any short-dated items up to four months before their expiry. And removed items in the month before they were due to expire. There were no expired medicines found from a selection that were checked. And there were several examples of packs being highlighted. 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.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy generally 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 available 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. The pharmacy's dispensing robot was serviced each year. Team members were able to contact a service engineer for any technical issues. The engineer provided remote support to help fix most issues. And were also available to provide on-site support, usually within 12 hours.

The pharmacy 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.

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.