General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Well, 244 Barnsley Road, Cudworth, BARNSLEY, South Yorkshire, S72 8SS

Pharmacy reference: 1039078

Type of pharmacy: Community

Date of inspection: 15/05/2019

Pharmacy context

This is a community pharmacy on a parade with other small shops in the residential village of Cudworth in Barnsley, South Yorkshire. The pharmacy sells over-the-counter medicines and dispenses NHS prescriptions. It also dispenses private prescriptions. The pharmacy team offers advice to people about minor illnesses and long-term conditions. And offers services including medicines use reviews (MURs), flu vaccinations and the NHS New Medicines Service (NMS). It also supplies medicines in multi-compartmental compliance packs to people living in their own 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 has adequate processes and procedures, so the team can manage the risks to its services. And it keeps the records it must by law. The pharmacy advertises how people can provide feedback and raise concerns. But the pharmacy team members cannot demonstrate how they have used the feedback to improve its services. The pharmacy keeps people's private information safe. It has adequate processes available to its team members, to help protect the welfare of vulnerable people. And the pharmacy team members know what to do if they have a safeguarding concern. The pharmacy's team members record errors that happen with dispensing. And they discuss their learning. They sometimes use this information to learn and make changes to help prevent similar mistakes happening again. But, they don't always record all the details of why errors happen. So, they may miss out on learning opportunities.

Inspector's evidence

The pharmacy had a set of standard operating procedures (SOPs) in place. These provided the team with information on how to perform tasks supporting the delivery of services. The SOPs covered procedures such as taking in prescriptions and dispensing. The team members were seen working in accordance with the SOPs. The SOPs were reviewed every 2 years. This ensured they reflected the current practice. The pharmacy defined the roles of the pharmacy team members in each SOP. The SOP showed who was responsible for performing each task. The team members knew how important it was to ask the pharmacist if there was a task they were unsure about. Or felt unable to deal with.

The pharmacy had a process in place to report and record near miss errors that were made while dispensing. The pharmacist typically spotted the error and then let the team member know they had made an error. But the pharmacist did not give specific details of the error. So, the team member identified their own error, which helped with their learning. The team members were encouraged to record details of their own errors on to a log. But the pharmacist often made the record. The records included the time and date of the error. But the team didn't regularly record the causes of the errors. The records were then transferred onto an online error reporting system called Datix. The team did not make records for each near miss. This was because they were often too busy to do so. The errors were not formally analysed. But the team did try and spot any common or recurring errors. An example given was the incorrect selection of co-codamol tablets and capsules. They had separated them in the dispensary to prevent the errors happening again. The pharmacy recorded details of dispensing incidents electronically. The team printed off the record for future reference. And the mistakes were reported to the superintendent pharmacist.

The pharmacy had a notice attached to a wall in the retail area which contained information on how to make a complaint. The pharmacy organised an annual survey to establish what people thought about the service they received. But they could not give an example of how they had improved the services they offered after feedback that had been received.

The pharmacy had appropriate professional indemnity insurance facilities. The responsible pharmacist notice displayed the correct details of the responsible pharmacist on duty. The pharmacy kept a responsible pharmacist record which complied with legal requirements. It maintained complete records

for private prescription and emergency supplies. And retained completed certificate of conformities following the supply of an unlicensed medicine.

A sample of controlled drug (CD) registers were looked at. It included completed headers and entries made in chronological order. The pharmacy maintained running balances. And they were scheduled to be checked every week. But this did not always happen. A random CD item was balance checked and verified with the running balance in the register (Sevredol 20mg X 70). The pharmacy completed a CD destruction register for patient returned medicines.

The pharmacy held records containing personal identifiable information in staff only areas of the pharmacy. Confidential waste was placed into a separate bin to avoid a mix up with general waste. The confidential waste was destroyed periodically. The pharmacy stored prescription medication waiting to be collected, in a way that prevented people's confidential information being seen by members of the public. And it positioned its computer screens to ensure confidential information wasn't on view to the public. The computers were password protected. All the team members had signed confidentiality agreements.

The pharmacist on duty had completed training via the Centre for Pharmacy Postgraduate Education (CPPE) on safeguarding the welfare of vulnerable people. Every team member had completed training that was provided by the company. The team members gave several examples of symptoms that would raise their concerns. And to escalate these concerns, they would discuss them with the pharmacist on duty, at the earliest opportunity. But the team did not have a guide or any other documentation available to them which guided them on how to manage or report a concern.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy employs people with the right skills and qualifications to undertake the tasks within their roles. The pharmacy supports its team members to complete training. And this helps them improve their knowledge and skills. They tailor their training to meet their own needs.

Inspector's evidence

A locum pharmacist was on duty during the inspection. And was supported by one full-time and three part-time NVQ2 qualified dispensers. An accuracy checking technician (ACT) from a neighbouring Well pharmacy joined the team during the inspection to provide additional support. The pharmacy also employed a full-time resident pharmacist, a full-time ACT, three part-time NVQ2 qualified pharmacy assistants, a part-time counter assistant and two part-time delivery drivers. But they were not present during the inspection. The team were observed supporting each other during the inspection. The team members were able to work overtime to cover any planned or unplanned absences. The pharmacy could also ask for cover from staff from other local branches in the event of an emergency.

The pharmacist on duty supervised the team members. And they involved the pharmacist in offering advice to people who were purchasing over-the-counter products for various minor ailments. They carried out tasks and managed their workload in a competent manner. And they asked appropriate questions when selling medicines that could only be sold under the supervision of a pharmacist. The team members accurately described the tasks that they could and could not perform in the pharmacist’s absence.

The team members felt they were actively encouraged to continue ongoing learning. The team members completed learning about pharmacy related topics such as medicines and health conditions through reading trade press materials and working through training modules that were provided by the company. But not all team members received set times during the working day to train. And so, they did some training in their own time. The training modules were available on an online training portal called e-expert. Some of the modules were mandatory and some could be done voluntarily e.g. if a team member had an interest in a particular subject. A team member demonstrated her training record. It showed that she had completed 88 per cent of the mandatory modules.

The team members received a performance review with their line manager every six months. The reviews were designed to allow the team to give feedback on how to improve the pharmacy's service, discuss various aspects of their performance, including what they had done well and what could be improved. All team members were due to receive an appraisal within the next few months. A pharmacy assistant was currently training to become a pharmacy technician. But she was struggling to dedicate enough time to her course. She discussed this with the resident pharmacist. And she was provided set training time.

The team described how they would raise professional concerns. The pharmacy had a whistleblowing policy. So, the team members could raise a concern anonymously.

The team were asked to meet various targets. These included retail sales, prescription volume and the number of medicine use review (MUR) and New Medicines Service (NMS) consultations completed. The

team said that they did not feel under pressure to achieve the targets. And would only try to deliver a service if it was in the best interest of the person.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is secure and well maintained. The temperature in the premises is not well controlled. And so, the team often find it uncomfortable to work on warm days

Inspector's evidence

The pharmacy used the ground and first floor of the premises. The ground floor contained the retail area and the main dispensary. The first floor had a separate dispensary to dispense multi-compartmental compliance packs. The premises portrayed a professional image. And it was generally clean, hygienic and well maintained. Floor spaces were clear with no trip hazards evident. There was a clean, well maintained sink in the dispensary used for medicines preparation and staff use. There was a WC which provided a sink with hot and cold running water and other facilities for hand washing. The area was free of clutter. The pharmacy had a signposted and sound proofed consultation room which contained adequate seating facilities. The room was smart and professional in appearance.

The temperature on the day of the inspection was around 20 degrees Celsius. Both dispensaries felt uncomfortably warm during the inspection. The team members said that they always found it troublesome to work and hard to concentrate on warm days. Lighting was bright throughout the premises.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides services to help people meet their health needs. It stores, sources and manages medicines safely. It has adequate processes to ensure the medicines it supplies to people are fit for purpose. The pharmacy supplies some people's medicines in multi-compartmental compliance packs to help them remember to take their medicines. And it sometimes gives people taking high-risk medicines advice. But the team don't always give written information to people to help them take their medicines correctly.

Inspector's evidence

People could access the pharmacy from the street, up a step and through a push/pull door. The pharmacy did not have any facilities in place, such as a ramp, to assist wheelchair users access the premises. People sometimes knocked on the entrance door to get the team's attention if they needed help. But there were no instructions telling people to do this. The services on offer, and opening times were advertised in the front window. There were adequate seating facilities for people waiting for prescriptions. Large print labels were provided on request. The team members had access to the internet. Which they used to signpost people requiring a service that the team did not offer. People could choose from a wide range of healthcare related leaflets to take away.

Stickers were attached to prescriptions to alert the team to provide advice or complete actions on hand out. For example, information about interactions or the presence of a fridge or a controlled drug that needed to be added to the bag. An audit trail was in place for dispensed medication using dispensed by and checked by signatures on labels. The dispensary had a manageable workflow with separate, areas for the team members to undertake the dispensing and checking parts of the dispensing process. Baskets were available to hold prescriptions and medicines. This helped the team to stop people’s prescriptions from getting mixed up. The team used different coloured baskets to indicate urgency and which prescriptions required delivery. The pharmacy had a procedure in place to highlight dispensed controlled drugs, that did not require safe custody. This helped the team ensure that the medicine could not be supplied to people after the prescription had expired. The pharmacy used clear bags to store dispensed fridge and CD items. Which allowed the team to do a further check of the item against the prescription. And by the person during the hand out process.

The pharmacy did not have a process in place to identify people who were prescribed high-risk medicines such as warfarin. The team members said that the resident pharmacist usually spoke with people prescribed warfarin and did some basic checks with them. But they were unsure what the checks were and if any records of the checks were made. The team members were aware of the pregnancy prevention programme for females who were prescribed valproate. And they were aware of the risks and demonstrated the advice they would give people in a hypothetical situation. But they did not have access to any literature about the programme that they could provide to people.

People could request for their medicines to be dispensed in multi-compartmental compliance packs. The team members were responsible for ordering the person’s prescription. And they did this around a

week in advance, so they had ample time to manage any queries. And then the prescription was cross-referenced with a master sheet to ensure it was accurate. The team queried any discrepancies with the person's prescriber. The team always checked with people if they required any items that they didn't supply in the packs before ordering. The team recorded details of any changes, such as dosage increases and decreases. The packs were clearly labelled. And the team included descriptions of the medicines it contained. Which helped people easily identify their medicines. The team did not always supply the packs with patient information leaflets.

The pharmacy kept records of the delivery of medicines from the pharmacy to people in their homes. The records included a signature of receipt. A note was posted to people when a delivery could not be completed. The note advised them to contact the pharmacy.

The pharmacy supplied people with owing slips on occasions when it could not supply the full quantity prescribed. One slip was given to the person. And one kept with the original prescription for reference when dispensing and checking the remaining quantity. The team attempted to complete the owing the next day.

The pharmacy stored pharmacy (P) medicines behind the retail counter. These medicines could only be sold in a pharmacy, and under the supervision of a pharmacist. The storage arrangement prevented people from self-selecting these medicines.

The team checked the expiry dates of the stock every three months. And they kept records of the activity. They used alert stickers to highlight medicines that were expiring in the next six months. The team recorded the date the pack was opened on liquid medicines. This allowed them to identify medicines that had a short-shelf life once they had been opened. And check that they were fit for purpose and safe to supply to people.

The team were not currently scanning products or undertaking manual checks of tamper evident seals on packs, as required under the Falsified Medicines Directive (FMD). No software or scanners were available to assist the team to comply with the directive. The team had completed training on how to follow the directive.

The team used digital thermometers to record fridge temperature ranges. A sample of the records were looked at. And the temperatures were always within the correct range. But the temperature range had not been recorded on the day before, or on the day of the inspection.

The pharmacy obtained medicines from several reputable sources. It received drug alerts via email and the team actioned them immediately. The alerts were printed and stored in a folder. The pharmacy kept a record of the action that was taken following the recall.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The equipment the pharmacy uses in the delivery of its services is clean, safe and protects people's confidentiality.

Inspector's evidence

The pharmacy had several reference sources available. And the team had access to the internet as an additional resource. The resources included hard copies of the current issues of the British National Formulary (BNF) and the BNF for Children. The pharmacy used a range of CE quality marked measuring cylinders. And it had tweezers and rollers available to assist in the dispensing of multi-compartmental compliance packs.

The medical fridge was of an appropriate size. The medicines stored inside were well organised.

The computers were password protected and access to people's records were restricted by the NHS smart card system.

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.