General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Well, 12 Hoyland Road, Hoyland Common, BARNSLEY, South Yorkshire, S74 0LY

Pharmacy reference: 1039097

Type of pharmacy: Community

Date of inspection: 13/06/2019

Pharmacy context

This is a community pharmacy in the Hoyland area of Barnsley, South Yorkshire. The pharmacy mainly sells over-the-counter medicines and dispenses NHS and private prescriptions. It also provides a range of services such as medicine use reviews (MURs), the NHS new medicines service, seasonal flu vaccinations and a minor ailments service. It also supplies people with emergency hormonal contraception and supervised consumption of methadone. And the pharmacy supplies medicines in multi-compartmental compliance packs to people 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	1.2	Good practice	The pharmacy team members are good at recording any errors that happen during dispensing. And they analyse the errors regularly and discuss their learning together. And they use this information to make changes to their working environment to help prevent similar mistakes happening again.
2. Staff	Standards met	2.4	Good practice	The pharmacy team members are open and honest when discussing any mistakes and they share their learning regularly. They have appraisals to plan their personal development. And they can suggest and implement ways to improve the services the pharmacy provides to people. The team members work together to achieve common goals.
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 it cannot show how it has used the feedback to improve its services. The pharmacy keeps people's private information safe. It has processes available to its team members, to help protect the welfare of vulnerable people. The pharmacy team members are good at recording any errors that happen during dispensing. And they analyse the errors regularly and discuss their learning together. And they use this information to make changes to their working environment to help prevent similar mistakes happening again.

Inspector's evidence

The pharmacy had a set of standard operating procedures (SOPs) in place. And these were stored electronically and were reviewed on a two-year rolling cycle. All the team members had read the SOPs that were relevant to their role. The team members were required to complete a short assessment after they had read an SOP. The assessment tested their knowledge of the SOP. The team members said they would ask the pharmacist if there was a task they were unsure about or felt unable to deal with.

A process was in place to report and record near miss errors that were made while dispensing. The pharmacist typically spotted the error and then made the team member aware of it. And then asked them to rectify it. The team member who made the error then recorded the details of the error on an online reporting system called Datix. The details recorded included the time, date and cause of the error. The regular pharmacist analysed the near misses each month. And the findings were documented and discussed with the team during a monthly team meeting. The team members had recently discussed how they should look out for medicines that looked or sounded similar (LASAs). They showed the hazard stickers affixed on stock shelves next to several LASAs. The team members said the stickers reminded them to take extra care. The pharmacist said that she had noticed a marked reduction in the number of errors involving LASAs over the last few months. The pharmacy had a process in place to record, report and analyse dispensing errors that had been given out to people. It recorded the details of the errors on to an electronic reporting form on Datix and the form was sent to the superintendent pharmacist's team to be analysed. The form was printed and filed for future reference. The details recorded included the reason why the error had happened and what the team had done to prevent similar errors happening in the future. The pharmacy had recently supplied a medicine in error to a person. The error was discussed with each team member to allow them to learn from it. The team members were reminded of their responsibilities when dispensing and to ensure they used a three-way check process each time a medicine was dispensed.

The pharmacy did not display the details of how people could make a complaint. The pharmacy obtained feedback from people who used the pharmacy, through a community pharmacy questionnaire. The team members said the feedback was generally positive. But they were unsure if areas of practice that required improvement had been identified. They were unable to provide any examples of how they had used feedback to improve their services.

The pharmacy had up to date professional indemnity insurance.

The responsible pharmacist notice displayed the correct details of the responsible pharmacist on duty. The responsible pharmacist register was correctly completed each day. A sample of controlled drug (CD) registers were looked at and were found to be in order including completed headers, and entries were being made in chronological order. Running balances were maintained and audited every month. A random CD item was balance checked and verified with the running balance in the register (Dexamphetamine 5mg X 168). The pharmacy recorded the destruction of patient returned CDs. The pharmacy kept complete records of private prescription supplies and supplies of unlicensed medicines. The pharmacy kept records of medicines that were supplied to people in an emergency. But the team often used dispensing labels to record the person's name and address. And these may fade in time.

A privacy policy was on display in the retail area. It outlined how the pharmacy protected their private information. The pharmacy had an information governance (IG) policy in place. It contained information on how the team should protect people's information and data. The team were clear of the importance of protecting the confidentiality of the people they provided services to. The pharmacy stored confidential waste in separate containers. The waste was collected by a third-party contractor who arranged its destruction.

The pharmacist on duty had completed training on safeguarding the welfare of vulnerable adults and children via the Centre for Pharmacy Postgraduate Education (CPPE). Other team members had completed a company training course. The team members gave several examples of symptoms that would raise their concerns. But a formal incident handling and reporting process was not available to the team. The team explained that they would always bring any potential concerns to the attention of the on-duty pharmacist. The team had not had any concerns to deal with to date.

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 their own needs. And they get protected training time each month. The team members work openly and honestly, and regularly discuss patient safety. And they are encouraged to feedback their ideas to improve services.

Inspector's evidence

At the time of the inspection, the team members present were the full-time resident pharmacist, who was also the pharmacy manager and three pharmacy assistants. Other team members who were not present included a pharmacy assistant and the delivery driver. The team members often worked overtime to cover both planned and unplanned absences. They were not permitted to take time off in December, as this was the pharmacy's busiest period.

The pharmacist 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 was aware of what could and could not happen in the pharmacists' absence.

The pharmacy had a structured process to help its team members to engage in ongoing learning. The team had access to an online learning programme called e-Expert. The programme consisted of several modules that the team worked through. The modules were often mandatory and were based on various topics or new SOPs. Other modules could be completed voluntarily and were often done when team members wanted to learn about a certain healthcare topic. A team member had recently learned about the medicine methotrexate, as she dispensed it many times but felt she did not know much about it. All team members were provided with protected learning time each month.

The team members attended a team meeting which was held every month. The meetings were an opportunity for the team to give feedback and suggest ways they could improve the service. The team members discussed patient safety and talked about any errors openly and honestly. They could suggest ways to make improvements to the service provided. The team members said they had discussed and implemented new ideas to improve the prescriptions collection and delivery service. This included giving the delivery driver specific delivery instructions, such as 'do not deliver after 3pm'. The team also received a monthly newsletter from the company head office. The newsletter focused on a specific topic for the team to discuss. The team had recently discussed the safe delivery of medicines. The team members signed the newsletter to confirm that they had understood its contents.

The pharmacy had a structured performance appraisal process in place. The appraisals were a one-to-one conversation between a team member and the pharmacist. The appraisals were an opportunity for the team member to discuss what they enjoyed about their job and what they wanted to achieve in the future. They were set goals to achieve by the time the next appraisal took place.

The team members confirmed that they were able to discuss any professional concerns with the

pharmacist. And they were aware of how they could raise concerns externally if they required. A whistleblowing policy was in place. So, team members could raise a concern anonymously. The pharmacy set the team some targets to achieve. These included NHS prescription items and MUR consultations. The team members said they did not feel any pressure to achieve the targets.

Principle 3 - Premises ✔ Standards met

Summary findings

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

Inspector's evidence

The pharmacy dispensary and retail area appeared clean, hygienic and well maintained. The floor spaces were clear and there were no obvious trip hazards. There was a clean, well maintained sink in the dispensary used for medicines preparation. There was a WC and a sink on the first floor with hot and cold running water and other facilities for hand washing. The area was free of clutter. The pharmacy had a sound proofed consultation room which contained adequate seating facilities. The room was smart and professional in appearance. The lighting was bright, and the temperature was comfortable throughout inspection. The overall appearance of the premises was professional, including the exterior which portrayed a professional healthcare setting.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy is accessible to people and it provides services to support people's health needs. The pharmacy has robust procedures that the team members follow when they dispense medicines into multi-compartmental compliance packs. They provide information with these packs to help people know when to take their medicines and to identify what they look like. But this information is sometimes not specific and so, people may not be able to properly differentiate between their medicines. The pharmacy sources its medicines from licenced suppliers. And it generally stores and manages it medicines appropriately. It date checks its medicines regularly. But occasionally, some out of date medicines have been missed. And so, it cannot be certain that these medicines are fit for purpose.

Inspector's evidence

The pharmacy had level access from the street. The pharmacy advertised the services it offered via displays in the main window. It provided seating 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.

The team members attached stickers to the prescriptions during the dispensing process to alert the pharmacist during checking of any issues, interactions or new medicines. And this also alerted team members during the hand out process, for example to the presence of a controlled drug or fridge line. The pharmacy had an audit trail for dispensed medication. The team achieved this by using dispensed by and checked by signatures on dispensing labels. The team members used separate areas to undertake the dispensing and checking parts of the dispensing process. They used baskets to keep prescriptions and medicines together. This helped prevent people’s prescriptions from getting mixed up.

The team members occasionally identified people who were prescribed high-risk medication such as warfarin. And they were given additional verbal counselling by the pharmacist, if the pharmacist felt there was a need to do so. But details of these conversations were not recorded on people’s medication records. So, the pharmacy could not show how often these checks took place. The pharmacy did not always assess the INR level. The team members knew about the pregnancy prevention programme for people who were prescribed valproate. And they described the advice they would give people in a hypothetical situation. They did not have access to information cards about the programme that they could provide to people. But they had completed an audit to identify people they regularly supplied valproate to. And did not find any people who met the criteria of the programme.

People could request for their medicines to be dispensed in multi-compartmental compliance packs. The team members dispensed the packs in a separate area at the back of the dispensary. They said that this was to prevent them having to break off from dispensing to serve people who were waiting in the retail area. The team were responsible for ordering the person’s prescription. 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 recorded details of any changes, such as dosage increases and decreases. The team supplied the packs with backing sheets which contained dispensing labels and information which would help people visually identify the medicines. But this information was not always clear. For example, a backing sheet was seen that described four separate medicines as

‘white round tablet’. And so, people would struggle to differentiate between these. The team supplied patient information leaflets to people each month as required by law.

The pharmacy kept records of the delivery of medicines from the pharmacy to people. The records included a signature of receipt. The pharmacy supplied people with a note when a delivery could not be completed. The note advised them to contact the pharmacy.

The pharmacy gave people owing slips 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 stock every three months and kept a record of the activity. The records were complete. But two out of date medicines were found after a random check. The team used alert stickers to highlight any stock that was expiring in the next 6 months. The date of opening was recorded on liquid medication that had a short-shelf life once opened. The team were not currently scanning products as required under the Falsified Medicines Directive (FMD). The pharmacy did not have any software installed to comply with the directive. The team had received training.

The team used digital thermometers to record fridge temperatures each day. A sample of the records evidenced temperatures were within the correct range.

The pharmacy obtained medicines from several reputable sources. It received drug alerts via email and the team actioned them. The pharmacy kept records of the action taken after the alert.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The equipment and facilities the pharmacy uses in the delivery of services are clean, safe and mostly protect 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 ones that were only used for dispensing methadone. The medical fridges were of an appropriate size. The medicines inside were well organised.

The computers were password protected and access to people's records were restricted by the NHS smart card system. And computer screens were adequately positioned to ensure confidential information wasn’t on view to the public. The computers were password 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.