General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: SKF Lo (Chemists) Ltd, Lundwood Medical Centre, Pontefract Road, Lundwood, BARNSLEY, South Yorkshire, S71 5PN

Pharmacy reference: 1039109

Type of pharmacy: Community

Date of inspection: 25/06/2019

Pharmacy context

This is a community pharmacy next to a GP medical centre in the village of Lundwood, Barnsley. It is open five days a week. The pharmacy sells over-the-counter medicines and dispenses NHS prescriptions. It also dispenses private prescriptions and provides a substance misuse service. 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 and to one local care home.

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 written procedures to protect the safety and wellbeing of people who access its services. It keeps the records it must have by law and generally keeps people's private information safe. It is well equipped to protect the welfare of vulnerable adults and children. The pharmacy team members try to learn from any errors that they make while dispensing. And they take steps to make sure the errors are not repeated.

Inspector's evidence

The pharmacy was accessible from the grounds of the medical centre. It had an open plan retail area which led directly into the dispensary. The pharmacy had a private consultation room to the side of the retail counter. The pharmacist used the bench closest to the retail counter to do final checks on prescriptions. This helped him supervise and oversee sales of over-the-counter medicines and conversations between team members and people.

The pharmacy had a set of standard operating procedures (SOPs). These were kept in a ring binder. An index was available which made it easy to find a specific SOPs. The SOPs covered various pharmacy processes. For example, taking in prescriptions, dispensing and the dispensing of medicines in multi-compartmental compliance packs. The SOPs were prepared several years ago and were scheduled to be reviewed every two years to make sure they reflected the current practice. But the pharmacy had missed the last review date (April 2019). All the team members had read and signed the SOPs that were relevant to their role. 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 said they would ask the pharmacist if there was a task they were unsure about. Or felt unable to deal with.

The pharmacy had a process to report and record near miss errors that were spotted during dispensing. The pharmacist typically spotted the error and then informed the dispenser that they had made an error. The team members then discussed why the error had happened. The error was then rectified by the dispenser and then passed to the pharmacist for another check. The dispenser then made a record of the error into a near miss log. The records contained details such as the time and date of the errors. But the team did not record the reason why the error may have had happened. And so, they may have missed out some learning opportunities. Every month, the pharmacist analysed the near miss log to check for any patterns or common trends. The pharmacist then informally discussed what he found with the team members while they were working. The team members said that they had recently discussed the most common error, which was mixing up prednisolone and propranolol. They had decided to separate them on the dispensary shelves to prevent them being picked up in error. The pharmacy used a similar process to record and report dispensing incidents. These types of incidents were rare. The pharmacy recorded such incidents electronically and kept the records for future reference. The records were also sent to the company head office for analysis.

The pharmacy had a leaflet which advertised how people could make comments, suggestions and complaints. The leaflet was available for people to self-select. The pharmacy completed a feedback survey each year. It asked people who visited the pharmacy to complete a questionnaire. But the team members were unsure of the results of the latest survey. And so, they may have missed the opportunity to improve the pharmacy's services.

The pharmacy had up-to-date professional indemnity insurance. The responsible pharmacist notice displayed the correct details of the responsible pharmacist on duty. Entries in the responsible pharmacist record complied with legal requirements. A sample of controlled drug (CD) registers were looked at and were found to be in order including completed headers, and entries made in chronological order. The pharmacy kept running balances, but they were not checked regularly. For example, the last check of the balance of MST 100mg tablets was in November 2017 and in October 2018 for morphine 10mg/ml ampoules. The running balance of morphine 10mg/ml ampoules matched the physical stock. The pharmacy correctly used a CD destruction register for patient returned medicines. It also kept complete records of supplies from private prescriptions. No records of emergency supplies were seen. The pharmacy kept the certificates of conformity with complete details as required by the Medicines and Healthcare products Regulatory Agency (MHRA).

The team held records containing personal identifiable information in areas of the pharmacy that only team members could access. Confidential waste was placed into a separate bin to avoid a mix up with general waste. The confidential waste was destroyed periodically. A privacy notice was on display in the retail area. The team members understood the importance of keeping people's information secure. The pharmacy had recently completed a check of its procedures and tried to identify and improve how it kept people's information secure. The team members had implemented a system to use separate delivery sheets for each person. Previously, the delivery driver used a sheet with a list of people's names and addresses on one sheet. And so, people who were signing the sheet could see the other people's names and addresses.

The regular pharmacist had completed training via the Centre for Pharmacy Postgraduate Education on safeguarding the welfare of vulnerable people. The pharmacy did not have a policy on managing a safeguarding concern. And so, the team may not know how to effectively raise and manage a potential concern. The team members claimed that they had completed some training but there was no evidence available to confirm this.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy employs enough team members to manage the services it provides. The team members complete training when they can, to ensure their knowledge and skills are refreshed and up to date. And they can raise professional concerns when necessary.

Inspector's evidence

The regular pharmacist was on duty at the time of the inspection and supported by two full-time pharmacy assistants and a part-time pharmacy technician. Two part-time pharmacy assistants and the delivery driver were not present. The pharmacist had worked at the pharmacy for several years and was also the pharmacy's manager. The pharmacist knew many of the people who used the pharmacy and many people were seen addressing him by his first name. And, asking him for advice of various healthcare related topics. The pharmacist felt he had an adequate number of team members to manage the dispensing workload. This was reflected in the relatively short time people had to wait for their prescriptions to be dispensed. The team members did not take time off in the few weeks before Christmas. As this was the pharmacy's busiest period. The team members worked overtime to cover each other's absences.

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 pharmacy did not provide its team members with a structured process for them to keep their knowledge and skills up to date. But it encouraged them to read literature about pharmacy services and products that the pharmacy received in the post. This helped them ensure they provided correct and relevant advice to people. The pharmacy encouraged the team to attended evening training events that were organised by external contractors. The team had recently attended an event on helping people with minor ailments.

The team did not have regular, formal meetings. But as it was a small team, the team members discussed topics such as company news, targets and patient safety, when the pharmacy was quiet. If a team member was not present during the discussions, they were brought up to speed the next time they attended for work. The team members openly and honestly discussed any mistakes they had made while dispensing and discussed how they could prevent the mistakes from happening again. The team had recently put an alert sticker on the shelf edge where GTN spray was stored. The sticker's purpose was to remind staff to make sure they picked the correct pack size, i.e. the 180 or 200 dose spray. The team received alert email from the company head office. A recent email had reminded the team to take care when selecting methotrexate 2.5 and 10mg to stop them being mixed up. The pharmacist had separated the two strengths on the dispensary shelves. This was checked and verified.

The pharmacy supported its team members with a performance appraisal every year. The appraisals were an opportunity for the team members to discuss what parts of their roles they felt they enjoyed

and which parts they felt they wanted to improve. They were also able to give feedback on how to improve the pharmacy's services. And discuss their personal development.

The team members said that they were able to discuss any professional concerns with the pharmacist or with the company head office. They were not aware of a company whistleblowing policy. And so, the team may find it difficult to raise a concern anonymously.

The pharmacy set several targets for its team to achieve. These included services and prescription volume. The team members said that the targets were reasonable and achievable. But they were not under any pressure to achieve them.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean, secure, adequately maintained and portrays a professional image. It has a sound-proof room where people can have private conversations with the pharmacy's team members.

Inspector's evidence

The pharmacy was clean and portrayed a professional image. The benches in the dispensary were cluttered with baskets containing prescriptions and medicines, and various miscellaneous items. But this improved as the inspection progressed. Floor spaces were clear with no trip hazards evident. There was a clean, well-maintained sink in the dispensary for medicines preparation and staff use. There was a WC which had a sink with hot and cold running water and other facilities for hand washing. Bins containing medicines for disposal were stored in the WC.

The pharmacy had a sound-proofed consultation room which contained adequate seating facilities. The room was smart and professional in appearance. The temperature was comfortable throughout the inspection. Lighting was bright throughout the premises.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides an appropriate range of services to help people meet their health needs. It generally stores, sources and manages its medicines safely. And it identifies and manages its risks adequately. The pharmacy team members help people to safely take high-risk medicines. And they generally manage the risks associated with dispensing medicines in multi-compartmental compliance packs.

Inspector's evidence

There was step-free access into the pharmacy. People who used the pharmacy could use the GP medical centre car park. The pharmacy advertised its services and opening hours near the entrance. It also displayed contact details of other pharmacies in the local area. Seating was provided 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. A wide range of healthcare related leaflets were available for people to select and take away.

The team members had access to various stickers that they could use to alert them to issues before they handed out medicines to people. For example, interactions between medicines 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 attached alert stickers to prescriptions to highlight people who were receiving high-risk medicines like warfarin. The team members showed these prescriptions to the pharmacist before they handed any medicines to people. And the pharmacist then gave these people additional counselling, if he felt there was a need to do so. And the pharmacy retained details of these conversations for future reference. The pharmacy also recorded INR levels. The team were aware of the pregnancy prevention programme for people who were prescribed valproate. The team said that they were aware of the risks. And they demonstrated the advice they would give people in a hypothetical situation. The team had access to literature about the programme that they could provide to people to help them take their medicines safely. The team did a check to see if any of its regular patients were prescribed valproate. And met the requirements of the programme. The check identified two people. These people were contacted and given the appropriate advice.

The pharmacy supplied medicines in multi-compartmental compliance packs for people living in their own homes and living in one local care home. The team members completed the dispensing for these packs on a rear bench away from the retail counter. This was done to prevent any distractions, such as people waiting to be served. 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 members queried any discrepancies with the person's prescriber. And they recorded details of any changes, such as dosage increases/decreases, on the master sheets. The team supplied the packs with backing sheets which contained dispensing labels. And information which would help people visually identify the medicines. But a sample was looked at, and some of the information was either vague or missing. The team supplied patient information leaflets with the packs each month.

The pharmacy kept records of the delivery of medicines from the pharmacy to people. The records included a signature of receipt. And so, there was an audit trail that could be used to solve any queries. A note was posted to people when a delivery could not be completed. The note advised them to contact the pharmacy.

Owing slips were given to people on occasions when the pharmacy 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 pharmacy stored pharmacy only 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 kept records of the activity. The team members 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 members 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, scanners or an SOP were available to assist the team to comply with the directive. The team had not received any training on how to follow the directive. And the team members were not aware of any plans for the pharmacy to become compliant soon.

The pharmacy used digital thermometers to record fridge temperatures each day. A sample of the records were looked at. And the temperatures were always within the correct range.

The pharmacy obtained medicines from several reputable sources. Drug alerts were received via email to the pharmacy and actioned. The alerts were stored for future reference. The pharmacy kept a record of the action taken following an alert. It also had medical waste bins and CD denaturing kits to help the team manage medicinal waste.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy’s equipment is clean and safe. And the pharmacy uses it appropriately to protect people’s confidentiality.

Inspector's evidence

The pharmacy had copies of the BNF and the BNF for children for the team to use. And the team had access to the internet as an additional resource. The pharmacy used a range of CE quality marked measuring cylinders. And tweezers and rollers were available to help the team dispense multi-compartmental compliance packs. The fridge used to store medicines was of an appropriate size. And the medicines inside were organised in an orderly manner. All the electrical equipment looked in good condition and was working.

Prescription medication waiting to be collected was stored in a way that prevented people’s confidential information being seen by members of the public. And computer screens were positioned to ensure confidential information wasn’t seen by people. The computers were password protected to prevent any unauthorised access. The pharmacy had cordless phones so the team members take the phone away and have conversations with people 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.