General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Well, 2 Snape Hill Road, Darfield, BARNSLEY, South Yorkshire, S73 9JU

Pharmacy reference: 1039119

Type of pharmacy: Community

Date of inspection: 23/07/2019

Pharmacy context

This is a community pharmacy in a residential area of 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 it offers services including medicines use reviews (MURs), flu vaccinations, a substance misuse service 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	2.2	Good practice	The pharmacy is good at supporting its team members to ensure their knowledge and skills are up to date. It achieves this by providing its team members with a structured training programme and regular appraisals. The team members can tailor their training to help them achieve personal 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 suitable processes and written procedures to protect the safety and wellbeing of people who access its services. It mostly keeps the records it must have by law and keeps people's private information safe. The pharmacy team members have the knowledge necessary to protect the welfare of children and vulnerable adults. And they have some processes and training in place to support them. The pharmacy team members try to learn from any errors they make whilst dispensing. And they take steps to make sure the errors are not repeated.

Inspector's evidence

The pharmacy had an open plan retail area which led directly into the dispensary. It had a private consultation room to the side of the retail counter. The responsible 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 at the counter.

The pharmacy had a set of standard operating procedures (SOPs). And they were held electronically. The pharmacy's superintendent pharmacist's office reviewed each SOP every two years on a monthly rolling cycle. This ensured that they were up to date. 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 final checker typically spotted the error and then informed the dispenser that they had made an error. The dispenser made a record of the error onto an electronic reporting system called Datix. The records contained details such as the date of the error and the team members involved. The team members had recently discussed the importance of entering their errors straight away to make sure they did not forget to do so, and they took responsibility for their own errors. The team members discussed any errors with each other while they were making the entries on Datix. This was to allow them to learn from each other. The near miss errors were analysed each month for any trends and patterns. And the findings were discussed with the team in a monthly team meeting. The team members made several changes to prevent errors happening again. These included attaching alert stickers that read 'similar, now check' in front of medicines that had been commonly involved in picking errors. The pharmacy documented the details of the analysis for future reference. The pharmacy had a process to record dispensing errors that had been given out to people. It recorded these incidents on Datix. A copy of the report was sent to the superintendent pharmacist's office for analysis and kept in the pharmacy for future reference.

The pharmacy had a poster on display which advertised how people could make comments, suggestions and complaints. It contained the company head office address, email and telephone number. The pharmacy collected feedback from people through an annual survey and mystery shopper visits. The results of the latest annual survey were displayed in the consultation room. The team members said several people who used the pharmacy wanted the pharmacy to provide additional seating, so they could be comfortable while they were waiting for their medicines to be dispensed. The team members said that due to the size of the premises, there was little potential to install more seating. But they

always offered the seats in the consultation room to people, if the seats in the retail area were occupied.

The pharmacy had up-to-date professional indemnity insurance. The responsible pharmacist notice displayed the correct details of the responsible pharmacist on duty. But it was difficult to see from the retail area. Entries in the responsible pharmacist record complied with legal requirements. The pharmacy kept complete records of private prescription and emergency supplies. The pharmacy kept the certificates of conformity of special supplies. But they were not completed correctly as required by the Medicines and Healthcare products Regulatory Agency (MHRA). The pharmacy kept controlled drugs (CDs) registers. They were in order including completed headers, and entries made in chronological order. The pharmacy team was required to check the running balances against physical stock each week. The team members were sometimes unable to find the time to do this, but the checks were carried out at least once a month. The running balance of Elvanse 30mg capsules was checked and it matched the physical stock. The pharmacy kept complete records of CDs returned by people to the pharmacy.

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. The pharmacy explained how they stored and protected people information via a poster displayed in the retail area. The team members understood the importance of keeping people's information secure. And they had all completed training on information governance. They renewed their training each year via an online training system.

All the team members had completed training on safeguarding vulnerable adults and children via the online training system. And the regular pharmacist had completed additional training via the Centre for Pharmacy Postgraduate Education. The team members gave several examples of symptoms that would raise their concerns. And they said they would discuss their concerns with the pharmacist on duty, at the earliest opportunity. The team members had no guidance readily available to them to help them properly manage and report a potential concern. But they did have the contact details of the local safeguarding teams. And they said that they would contact the local safeguarding teams for advice if they had any concerns.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough team members to manage the services it provides. It reviews staffing levels to ensure they remain appropriate. The team members openly discuss ways to improve ways of working. And they regularly talk together about why mistakes happen, and how they can make improvements. The pharmacy is good at supporting its team members to ensure their knowledge and skills are up to date. It achieves this by providing its team members with a structured training programme and regular appraisals. The team members can tailor their training to help them achieve personal goals. And they feel comfortable to raise professional concerns when necessary.

Inspector's evidence

At the time of the inspection, the team members present were a relief pharmacist, a full-time accuracy checking technician (ACT), a full-time pharmacy assistant, a part-time pharmacy technician and a part-time pharmacy assistant. The regular full-time pharmacist was not scheduled to work but joined the team to help with the inspection. The regular pharmacist felt she had a suitable number of team members to manage the dispensing workload. She said 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 pharmacy could call on the help of team members from other local Well branches to cover planned and unplanned absences. The pharmacist explained that staff rotas had been recently reviewed after staff hours had been reduced.

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 were able to access the online training system to help them keep their knowledge and skills up to date. They received training modules to complete every month. Many of the modules were mandatory to complete. And the team members received set time during the working day to allow them to complete the modules without interruption. The team members were also able to voluntarily choose a module if they felt the need to learn about a specific healthcare related topic, or needed help carrying out a certain process. The pharmacy had an annual performance appraisal process in place. 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. A team member said she wanted to take on more of an administrative role within the pharmacy. Such as submitting paperwork and prescriptions for reimbursement. The team member said she discussed this at her last appraisal and was provided one to one training sessions to help her achieve her goal. The team member said that she had successfully achieved her goal and was pleased with the outcome.

The team held monthly formal meetings and discussed topics such as company news, targets and patient safety. If a team member was not present during the discussions, they were updated 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 recently discussed medicines that looked or sounded alike (LASAs). The team members said that these medicines were more likely to be involved in errors. And they highlighted the medicines they had more errors with. For example, amlodipine and amitriptyline, atenolol and allopurinol. The team members had also separated some of these items on the dispensary shelves to reduce the risk of mixing them up.

The team members said they were able to discuss any professional concerns with the manager or with the company head office. The pharmacy had a whistleblowing policy. So, the team could raise a concern anonymously. The pharmacy set several targets for its team to achieve. These included services and prescription volume. The team members said they were often unable to meet the targets. But they were not put under any pressure from the company and received regular support from their area manager.

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, it has a suitable room where people can speak to pharmacy team members privately.

Inspector's evidence

The pharmacy was clean and portrayed a highly professional image. The benches in the dispensary were kept tidy throughout the inspection. 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. 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 promotes the services it provides and takes appropriate steps to make sure people can access these services. The pharmacy has robust procedures the team members follow when they dispense medicines into multi-compartmental compliance packs. The pharmacy sources its medicines from licenced suppliers. And it generally stores and manages it medicines appropriately. The team members take steps to identify people taking high-risk medicines. And, they provide people with advice to help them take these medicines safely.

Inspector's evidence

The pharmacy was accessible via a small step in the street to a simple push/pull door. But there were no aids available to help people with mobility issues enter the premises. 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 pharmacy advertised its services and opening hours in the front window. Seating was provided for people waiting for prescriptions.

The team members regularly used various stickers that they could use as an alert before they handed out medicines to people. For example, to highlight interactions between medicines or the presence of a fridge line or a controlled drug that needed handing out at the same time. The team members signed the dispensing labels to indicate who had dispensed and checked the medication. And so, a robust audit trail was in place. 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 stop people's prescriptions from getting mixed up. The team had a robust process to highlight the expiry date of CD prescriptions awaiting collection in the retrieval area. 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 team attempted to complete the owing the next day. The pharmacy kept records of the delivery of medicines from the pharmacy to people. The records included a signature of receipt. And so, an 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.

The pharmacy had recently introduced a new system of dispensing many of the prescriptions it received, at the company's offsite dispensing hub. The system was designed to reduce the team's dispensing workload and allow the team members more time to offer services such as medicine use reviews. The pharmacy had been using the system for around six weeks and each team member had received comprehensive training before the process went live. The team firstly assessed whether a prescription was suitable to be dispensed at the hub. Generally, any prescriptions that were for CDs or fridge items were not sent. The team also avoided sending prescriptions for more urgent items such as antibiotics. Once it was established that a prescription was suitable to be sent to the hub, it was accuracy and clinically checked by the pharmacist. Only the pharmacist, using their personal smart card and password, was able to perform the clinical and accuracy check and release prescriptions to the hub. The details of the prescription were then sent electronically to the hub. And the prescription was dispensed via dispensing robots. It took three days for prescriptions to be processed and the medicines to be received from the hub. The pharmacy had the ability to dispense some items from a prescription

at the pharmacy, and still send the prescription to the hub for the remaining items to be dispensed. The team marked all prescriptions that were sent to the hub and stored them in a separate box to prevent them being mixed up with other prescriptions. The pharmacy received the medicines that had been dispensed at the hub in sealed bags. The bags were then coupled with the relevant prescription. And then scanned on the shelves in the prescription retrieval area, ready for collection. The pharmacy had carried out a quality assurance audit of the first 300 medicines that were dispensed and returned to the pharmacy via the hub. The team members had physically opened the sealed bags and completed a check of all the medicines. No errors were found during the audit. A daily quality assurance audit was in place. The team members chose a sealed bag that had been received from the hub at random and undertook a check. The pharmacy recorded the details of these daily checks. And any issues were to be reported to the company's superintendent's office. The team had not encountered any issues to date.

The pharmacy often dispensed high-risk medicines for people such as warfarin. The pharmacist often gave the person additional advice if 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 demonstrate how often these checks took place. INR levels were always assessed in the pharmacy. The team were aware of the pregnancy prevention programme for people who were prescribed valproate. The team said 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. Two people were identified. And the team gave them the appropriate counselling. The pharmacy used clear bags to store dispensed insulin. This allowed the team member and the person collection to undertake a final visual check of the medicine before the person collected the medicine.

The pharmacy supplied medicines in multi-compartmental compliance packs for people living in their own homes and living in three local care homes. And the pharmacy supplied the packs to people on either a weekly or monthly basis. The team members were responsible for ordering the person's prescription. And they did this around a week in advance. And then they cross-referenced the prescription with a master sheet to ensure it was accurate. The team members queried any discrepancies with the person's prescriber. The team members recorded details of any changes, such as dosage increases and decreases, on the master sheets. They dispensed the packs in a first-floor room. This was to make sure they weren't distracted while dispensing. The packs had backing sheets. And the sheets contained information to help people visually identify the medicines. The team did not routinely provide patient information leaflets with the packs. This is not in line with requirements.

Pharmacy only medicines were stored behind the pharmacy counter. The storage arrangement prevented people from self-selecting these medicines. Every three months, the pharmacy team members checked the expiry dates of its medicines to make sure none had expired. And records were seen. The pharmacy used stickers to highlight stock that was within six months of expiring. Some short-dated stickers were seen on items on the dispensary shelves. But following a random check, two out-of-date medicines were seen on the dispensary shelves. These were brought to the attention of the team members. And they arranged the removal of the medicines. The team members recorded the date liquid medicines were opened on the pack. So, they could check they were in date and safe to supply. 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). The team had received training on how to follow the directive. The pharmacy had FMD software and scanners installed. The team was unsure of when they were to start following the directive. Drug alerts were received via email to the pharmacy and actioned. The alerts were printed and stored in a folder. And the team kept a record of the action it had taken. The pharmacy used digital thermometers to record fridge temperatures each

day. A sample of the records were looked at. And they were within the correct range.

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. The team used tweezers and rollers to help them dispense multi-compartmental compliance packs. The fridges used to store medicines were 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 could 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.