General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Green Arbour Pharmacy, 65 Green Arbour Road, Thurcroft, ROTHERHAM, South Yorkshire, S66 9DD

Pharmacy reference: 1039213

Type of pharmacy: Community

Date of inspection: 14/03/2023

Pharmacy context

This community pharmacy is on the main through road in the South Yorkshire village of Thurcroft, close to Rotherham. Its main services include dispensing prescriptions and selling over-the-counter medicines. It supplies some medicines in multi-compartment compliance packs, designed to help people to take their medicines. And it delivers some medicines to people's 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 identifies and manages the risks associated with most of its services effectively. It keeps people's confidential information secure. And it clearly advertises how people can feedback about its services. The pharmacy generally keeps the records it must by law. Pharmacy team members understand how to recognise and respond to safeguarding concerns to help protect vulnerable people. And they engage in regular conversations and learning to help reduce risk following mistakes they make during the dispensing process.

Inspector's evidence

The pharmacy had standard operating procedures (SOPs) to support its safe and effective running. These covered responsible pharmacist (RP) requirements, controlled drug (CD) management, dispensary processes and services. There was no index to support team members in locating a specific SOP efficiently. This meant it could be more difficult for team members to refer to SOPs to support them in managing a process if a query arose. The RP on duty was the pharmacy manager. They provided details of a current review of the SOPs that was taking place. And they confirmed they had read the SOPs when they took over as manager. Not all team members, including the RP had signed training records associated with individual SOPs relevant to their job role to confirm they had read and understood them. Team members on duty who had not signed the SOPs showed a clear understanding of how to complete tasks associated with their role. For example, asking appropriate questions when a managing a request for a Pharmacy (P) medicine. The pharmacy monitored training associated with the safe completion of dispensary tasks. For example, it had recently introduced a skills matrix to identify how competent its team members were in completing specific tasks. This involved self-assessment and supported learning through a buddy-arrangement with the pharmacy supervisor, who was a qualified dispenser. The RP had a role in overseeing this process.

The pharmacy had tools to support its team members in recording mistakes made and identified during the dispensing process, known as near misses. Team members were asked to look again at their work when a near miss was identified to help support their own learning, and they acted to correct their own near misses. Entries in the near miss record were consistent. But a section designed to record the action taken in response to a near miss was not always completed at the time a mistake occurred. A team member demonstrated recent action taken to reduce risk by separating different formulations of the same medicine within the dispensary drawers. The pharmacy had a procedure for reporting mistakes identified following supply of a medicine to a person, known as dispensing incidents. The RP discussed reporting the incident via an online portal, but the pharmacy did not keep records of the reports it made via this portal. The team recorded brief details of dispensing incidents, along with details of trends in near misses, drug alerts and prescribing interventions within its monthly patient safety review. The review also identified learning and action taken to reduce risk. And it formed part of a wider monthly team meeting.

The pharmacy had a complaints procedure and it advertised how people could provide feedback about its services through its practice leaflet. Team members understood how to manage feedback, and how to escalate feedback to the RP or SI if required. The pharmacy had safeguarding procedures in place, and its team members understood the importance of acting on safeguarding concerns to help protect

vulnerable people. Team members had completed some safeguarding learning to help them recognise and report concerns with assistance from the RP. The RP had completed level two safeguarding learning through the Centre for Pharmacy Postgraduate Education (CPPE) and within their previous employment within an NHS hospital. A member of the pharmacy team explained how they would respond if a person came into the pharmacy and asked for 'ANI,' an initiative to help provide a safe space for people experiencing domestic abuse. The team had considered particular vulnerabilities relating to the abuse, misuse, or overuse of over-the-counter medicines. And it monitored repeat requests for these medicines to support appropriate interventions.

The pharmacy had up-to-date indemnity insurance arrangements. No RP notice was displayed. A discussion highlighted the requirement to display a notice informing people who the RP in charge of the pharmacy was at any given time. And appropriate action was taken immediately to display the correct RP notice following this discussion. A sample of pharmacy records found them to be generally maintained in accordance with legal and regulatory requirements. There were some occasions when RPs did not sign out of the RP record, and team members did not always enter the prescribers' details correctly when dispensing a private prescription. The pharmacy kept its controlled drug (CD) register electronically. The pharmacy maintained running balances in the CD register and physical balance checks of stock against balances in the register took place frequently for solid-dose formulations. But physical balance checks of liquid medicines against the register occurred infrequently. This meant it could be more difficult for the pharmacy to investigate a discrepancy or answer a query if one arose. The pharmacy held its records relating to the supply of unlicensed medicines in accordance with the requirement of the Medicines and Healthcare products Regulatory Agency. The pharmacy had procedures in place to support the safe handling of patient information. It held personal identifiable information on computers and within areas of the pharmacy only accessible to staff. Confidential waste was held securely and up to recently was collected on a monthly basis by a shredding company. This arrangement had recently changed, and the pharmacy had been informed it would be provided with a heavy-duty shredder to manage its confidential waste moving forward.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough team members to manage its workload. And it has processes which appropriately support its team members learning needs. Pharmacy team members work well together, they share learning with each other on a regular basis. And they understand how to provide feedback about the pharmacy and can raise a professional concern if needed.

Inspector's evidence

The pharmacy team on duty consisted of the RP, a qualified dispenser, four trainee dispensers and a delivery driver. Another delivery driver, a medicine counter assistant and another trainee dispenser also worked at the pharmacy. A pharmacy technician, working in an accuracy checking role, also provided some part-time support to the pharmacy. There was no formal arrangement to backfill posts when team members were on leave. The team planned its workload and management of tasks to help ensure planned leave did not impact significantly on services. And it had on occasion received support from another pharmacy within the wider group or from locum staff when unplanned leave had impacted on the team. To support workload management the pharmacy had recently introduced a rota which meant team members rotated into different tasks throughout the working week.

The pharmacy had a high number of trainees and it had recognised this risk through the monitoring arrangements it had adapted with its skills and competency assessments. Team members enrolled on apprenticeship courses had a day off each week dedicated to their learning. In addition to this mandatory learning team members kept themselves up to date with learning associated with services. For example, the RP was in the process of ensuring team members completed learning associated with the NHS Pharmacy Quality Scheme. Pharmacy team members felt confident in asking questions about their learning. The pharmacy did not have specific targets related to its services. The RP discussed the benefits of building rapport with people through services such as the NHS New Medicine Service (NMS)

The pharmacy had a whistleblowing policy. And its team members understood how to provide feedback and escalate concerns at work. Pharmacy team members communicated via continual conversations at work and through sharing information via a secure messaging application. They also engaged in monthly team meetings, and a team member explained how they could contribute their ideas during these meetings. For example, when putting forward ideas to reduce risk following a review of patient safety events.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is adequately clean, secure, and suitable for the services provided. It has facilities to allow people to have a private conversation with a member of the pharmacy team.

Inspector's evidence

The pharmacy was appropriately secure and maintained. It was adequately clean and organised. Lighting throughout the premises was sufficient. Team members reported that the air conditioning system that maintained ambient room temperature had been switched off. This meant there was a reliance on using electric heaters in the dispensary during winter months. The public area of the pharmacy and the consultation room were particularly cold as there was no direct heating arrangements in these areas due to the air conditioning system being switched off. This increased the chance of damp forming in these unheated areas. Team members did not monitor room temperature. The consultation room was accessible to people who wished to speak to a team member in private. But the room appeared unfinished and this along with the lack of heating meant people may not feel fully at ease when using the room.

The pharmacy had a large public area leading through to a good size dispensary with plentiful amounts of work bench space. Workflow was organised with separate space for completing higher-risk tasks such as assembling medicines in multi-compartment compliance packs. The pharmacy's consultation room was accessed off the public area and was suitably protected from unauthorised access. Rooms off the dispensary provided office space and some storage space for stock and assembled medicines. Access to staff facilities were also provided in rooms off the dispensary.

Principle 4 - Services ✔ Standards met

Summary findings

Overall, the pharmacy makes its services accessible to people and it provides its services safely and manages them adequately. And its team members understand the need to signpost people to other pharmacies or healthcare providers should they be unable to provide a service. The pharmacy obtains its medicines from licensed sources. And it generally stores these medicines safely and securely. But it does not always use monitoring tools such as date checking records and robust temperature records to support it in doing this. This may on occasion limit the amount of information team members have to support them in ensuring that medicines are suitable and appropriate to supply to people.

Inspector's evidence

People accessed the pharmacy through a push/pull door at street level. The pharmacy advertised its services and opening hours for people to see. It had a small range of health information leaflets available for people to take, including a practice leaflet providing further information about the services it provided. Pharmacy team members knew how to signpost people to another pharmacy or healthcare provider should they not be able to provide a service or supply a medicine. The RP had recently organised an engagement meeting with the practice manager from a local surgery. Prior to the meeting the RP had identified ways the two healthcare providers could work together to help minimise risk. And following the meeting some changes to the frequency the surgery uploaded electronic prescriptions to the NHS spine had supported the pharmacy in managing its workload. The pharmacist had also used the meeting to explore effective and efficient communication channels between the pharmacy and surgery.

The pharmacy protected Pharmacy (P) medicines from self-selection as it displayed them behind screens close to the medicine counter. There were clear notices advising people to seek assistance from a team member if they wished to purchase a medicine held behind the screen. The RP provided examples of interventions that they conducted when dispensing prescriptions and consulting with people. For example, the RP had recognised the need to hold a face-to-face consultation with a person reporting adverse side effects from their medicine. This had led them to advise the person to immediately stop taking a medicine and supported the person in obtaining an urgent GP appointment to review their health. The pharmacy did not have a defined process for identifying most higher-risk medicines and as such there was potential to miss opportunities to offer additional counselling and information when supplying these medicines. It did identify CDs and cold chain medicines to prompt additional checks prior to supply of these medicines. And there was evidence of some shared learning associated with dispensing higher-risk medicines. For example, all team members had been briefed about the importance of dispensing 2.5mg tablets only when supplying methotrexate and were aware of the weekly dosage regimen for the medicine. A team member demonstrated their awareness of the risks associated with dispensing valproate to people in the at-risk group. And the pharmacy was engaging in a valproate supply audit which to date had not identified prescriptions for people within the at-risk group. The RP had a clear understanding of the requirements of the valproate Pregnancy Prevention Programme.

Pharmacy team members signed the ‘dispensed by’ and ‘checked by’ boxes on medicine labels when dispensing medicines. And they used baskets throughout the dispensing process to help keep medicines

with the correct prescription. The pharmacy kept audit trails associated with its delivery service and it had an effective process for managing medicines that it owed to people. It used the patient medication record (PMR) system to support it in supplying medicines in multi-compartment compliance packs. Computer records contained information relating to people's medicine regimens. A team member demonstrated how changes would be recorded on the PMR after being checked with the GP surgery. No evidence of recent records associated with changes were demonstrated. A sample of assembled compliance packs contained full dispensing audit trails. And the pharmacy routinely supplied patient information leaflets at the beginning of each four-week cycle of compliance packs. But team members did not physically apply backing sheets to the compliance packs during the dispensing process. A discussion highlighted the need to physically secure backing sheets in a safe manner to the compliance packs to avoid the risk of this supportive information being separated from the medicine. The pharmacy provided descriptions of the medicines inside the pack on a backing sheet. This helped people recognise their medication. But backing sheets did not contain mandatory adverse warnings related to the medicines held inside the compliance packs. The RP provided confirmation shortly after the inspection visit that this matter had been resolved.

The pharmacy sourced medicines from licensed wholesalers. It stored these medicines in an orderly manner, on shelves and in drawers throughout the dispensary. The pharmacy generally stored medicines subject to safe custody in an orderly manner within secure cabinets. But its out-of-date stock medicines and patient-returned medicines had built up and there was a need to ensure these were securely destroyed in a timely manner. The pharmacy had three fridges. Two were routinely used to store medicines. The pharmacy kept temperature records of these fridges. But there were some gaps within these monitoring records. Temperatures either side of the gaps identified the fridges had been operating between two and eight degrees Celsius as required. The thermometer for one fridge was showing a maximum reading of 14 degrees Celsius since its last reset. This was reset during the inspection, and it remained within two and eight degrees. The third fridge in the consultation room was not routinely used to hold stock. It was used to hold vaccines during the flu vaccination season. Its operational temperature was not currently monitored despite a small amount of bulky stock found to be stored inside. The RP was not aware that a team member had used the fridge as an overflow storage area from the allocated fridges. A discussion highlighted the need to either ensure the storage temperature had remained within two and eight degrees whilst the medicine was stored inside or to safely dispose of the medicine if this could not be guaranteed. The RP acknowledged the need to investigate and gain these assurances.

The pharmacy team reported completing regular date checking tasks. But it did not use a record to support the completion of these tasks. A check of dispensary shelves found one out-of-date medicine. The medicine had been highlighted clearly as being short dated, and there was evidence that this was routine practice. The RP was observed checking expiry dates as part of their final accuracy check. The pharmacy had appropriate medicine waste bins and CD denaturing kits available. The team received medicine alerts by email. And could demonstrate how it checked and responded to these alerts.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

Pharmacy team members have access to the equipment they require to provide the pharmacy's services. And they use the equipment in a way which protects people's privacy.

Inspector's evidence

The pharmacy had up-to-date reference resources available including access to the British National Formulary (BNF). Pharmacy team members could access the internet to help resolve queries and to obtain up-to-date information. The pharmacy's computer was password protected. And information displayed on computer monitors was not visible from the public area. The pharmacy stored bags of assembled medicines away from the public area to help protect people's privacy. The pharmacy had some clean equipment available for counting and measuring medicines. It highlighted equipment for measuring and counting higher-risk medicines and stored this separately from other equipment. This helped to reduce any risk of cross contamination. Equipment in its consultation room was stored safely and protected from unauthorised access. But some adrenaline ampoules held within the room had recently expired, these were brought to the direct attention of the RP. The RP confirmed that vaccination services were not currently being provided.

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.