General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Knights Birstall Pharmacy, The Old Salvation Army Hall, 74 Blackburn Road, Birstall, BATLEY, West Yorkshire, WF17 9PL

Pharmacy reference: 1039396

Type of pharmacy: Community

Date of inspection: 16/01/2020

Pharmacy context

The pharmacy is adjacent to a GP surgery in Birstall. Pharmacy team members dispense NHS prescriptions and sell a range of over-the-counter medicines. They offer services including medicines use reviews (MUR) and the NHS New Medicines Service (NMS). They provide seasonal flu vaccinations. And they supply medicines to some people in multi-compartment compliance packs. The pharmacy provides a substance misuse service, including supervised consumption.

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	4.1	Good practice	The pharmacy clearly advertises its services to people. And pharmacy team members regularly reach out to the local community to promote health and wellbeing.
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 with its services. It protects people's confidential information. And it generally keeps the records it must by law. Pharmacy team members know how to safeguard the welfare of children and vulnerable adults. They record and discuss mistakes that happen during dispensing. And they use this information to learn and reduce the risk of further mistakes. They don't always collect information about the causes of mistakes to help inform the changes they make. But when they do, they use the information to help make the most appropriate changes. Pharmacy team members follow written procedures to help them complete the required tasks safely and effectively.

Inspector's evidence

The pharmacy had a set of standard operating procedures (SOPs) in place. The sample checked were last reviewed in December 2017. And the next review was scheduled for December 2019. Pharmacy team members said the procedures were currently being reviewed by the superintendent pharmacist (SI). Pharmacy team members had read and signed the SOPs after the last review in 2017. The pharmacy defined the roles of the pharmacy team members in each procedure. The pharmacy employed two pharmacy technicians that were accredited to perform a final accuracy check of prescriptions (ACTs). The ACTs usually checked repeat prescriptions. And prescriptions were clinically checked by the pharmacist before being dispensed and assembled. The pharmacist annotated the prescriptions with a signature in a quadrant to confirm they had completed their clinical check. An ACT explained that if the pharmacist's signature was missing, they would return the prescription to the pharmacist before performing a final accuracy check. The pharmacy had a documented procedure in place for defining the role of the ACT. The procedure permitted ACTs to check prescriptions for any medicines. But, both ACTs had agreed locally with the pharmacist that they were not comfortable checking prescriptions for controlled drugs (CDs). So, the ACTs checked CD prescriptions. And these were checked again by the pharmacist before being packaged ready for collection or delivery.

The pharmacist or ACTs highlighted near miss errors made by the pharmacy team when dispensing. Pharmacy team members recorded their own mistakes. They discussed the errors made. But, they did not discuss or record much detail about why a mistake had happened. They usually said rushing or misreading the prescription had caused the mistakes. And, their most common change after a mistake was to double check next time. But they had made changes to separate some medicines and attach alert stickers to the edges of shelves to help prevent further errors. One example was them separating and highlighting indapamide and imipramine. The pharmacy technician analysed the data collected about mistakes every month. And she recorded her analysis. The records seen were comprehensive. And analysis was based on quantitative information, such as the number of different types of error occurring. There no analysis for patterns of causes. The pharmacy had a clear process for dealing with dispensing errors that had been given out to people. It recorded incidents using a template reporting form. Errors were discussed with the whole team. They discussed why the error might have happened. And they made changes to help prevent the same mistake again. Their changes were usually to separate the medicines and to add warning stickers to the shelves to highlight the risks. During discussions about errors, pharmacy team members had identified that distractions, especially when they were dispensing multi-compartment compliance packs, had caused several errors. In response they had designed and implemented a sign to attach to the door of the room where packs were

dispensed and checked. The sign reminded pharmacy team members not to disturb someone that was dispensing or checking a pack. And to either wait until they had finished or to tell the person they are waiting for them to come and find them later. Pharmacy team members said this had helped to reduce the number of distraction errors with pack dispensing.

The pharmacy had a procedure to deal with complaints handling and reporting. It had a practice leaflet available for customers in the retail area which clearly explained the company's complaints procedure. It collected feedback from people by using questionnaires. Pharmacy team members could not give any examples of any changes they had made after feedback to improve pharmacy services.

The pharmacy had up-to-date professional indemnity insurance in place. It had a certificate of insurance displayed. The pharmacy kept controlled drug (CD) registers complete and in order. It kept running balances in all registers. And these were audited against the physical stock quantity at least monthly. It audited methadone registers weekly. The pharmacy kept and maintained a register of CDs returned by people for destruction. And this was complete and up to date. It maintained a responsible pharmacist record on paper. This was also complete and up to date. The pharmacist displayed their responsible pharmacist notice to people. Pharmacy team members monitored and recorded fridge temperatures daily. They kept private prescription records electronically. In the sample seen, they often did not accurately record the date on the prescription. Pharmacy team members accurately recorded emergency supplies of medicines electronically. They recorded any unlicensed medicines supplied, which included the necessary information in the samples seen.

The pharmacy kept sensitive information and materials in restricted areas. It shredded confidential waste. Pharmacy team had completed training about the General Data Protection Regulations in 2018. They were clear about how important it was to protect confidentiality. And there was a documented procedure in place detailing requirements under GDPR. Pharmacy team members gave sound examples of situation where they would raise a safeguarding concern about a child or vulnerable adult. They raised their concerns with the technician manager or the pharmacist, who then contacted local safeguarding teams or head office for advice if necessary. The pharmacy had a documented procedure for safeguarding. And a list of local safeguarding contacts displayed in the dispensary. Registered pharmacy team members were required to complete training every two years. And they had last trained in 2019. Other pharmacy team members explained they had attended a local training event approximately four years ago. But the had not completed any formal training since. And newer pharmacy team members had not completed any formal training.

Principle 2 - Staffing ✔ Standards met

Summary findings

Pharmacy team members have the right qualifications and skills for their roles and the services they provide. They complete training and reflect on their skills and performance ad-hoc. And they tailor some of their learning to meet the needs of the pharmacy's services. They learn from the manager, pharmacist and each other to keep their knowledge and skills up to date. Pharmacy team members feel comfortable making suggestions to help improve pharmacy services.

Inspector's evidence

At the time of the inspection, the pharmacy team members present were a relief pharmacist, three pharmacy technicians, two dispenser and two counter assistants. Pharmacy team members completed training ad-hoc by reading various trade press materials. And by having regular discussions with the pharmacists about current topics. Pharmacy team members also discussed and read information about each health living topic before each campaign was launched every month. Pharmacy team members did not receive an appraisal or performance review. They explained that any learning needs were raised informally with the manager or pharmacist. And they supported them to address their needs by teaching and providing access to appropriate resources.

The dispenser explained she would raise professional concerns with the manager, pharmacist or superintendent pharmacist (SI). She felt comfortable raising a concern. And confident her concerns would be considered, and changes would be made where they were needed. The pharmacy had a whistleblowing policy. Pharmacy team members said they would look at the standard operating procedures (SOPs) to find out how to access the process. Pharmacy team members communicated with an open working dialogue during the inspection. They explained a change they had made after they had identified areas for improvement. The pharmacy had previously stored and sorted its medicines by brand name. Pharmacy team member had found it difficult to locate medicines, particularly when the same medicines, with two different brand names, were being stored in different locations. They explained that this had sometimes caused them to owe medicines to people unnecessarily. Pharmacy team members had discussed the issues. And decided to reorganise the medicines shelves so that medicines were store by their generic drug name. This meant that all brands of the same medicine were kept in the same place. They explained that medicines were now much easier to find. And this had helped to speed up the dispensing process and reduce the number of medicines owed to people. The pharmacy's owners did not ask the team to achieve any targets.

Principle 3 - Premises ✔ Standards met

Summary findings

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

Inspector's evidence

The pharmacy was clean and well maintained. All areas of the pharmacy were tidy and well organised. And the floors and passage ways were free from clutter and obstruction. There was a safe and effective workflow in operation. And clearly defined dispensing and checking areas. The pharmacy also had a dedicated area for preparing and checking multi-compartment compliance packs. It kept equipment and stock on shelves throughout the premises. The pharmacy had a private consultation room available. Pharmacy team members used the room to have private conversations with people. The room was signposted by a sign on the door.

There was a clean, well maintained sink in the dispensary used for medicines preparation. There was a toilet, with a sink providing hot and cold running water and other facilities for hand washing. Heat and light in the pharmacy was maintained to acceptable levels. The overall appearance of the premises was professional, including the exterior which portrayed a professional healthcare setting. The professional areas of the premises were well defined by the layout and well signposted from the retail area.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's services are easily accessible to people, including people using wheelchairs. And the pharmacy provides its services safely and effectively. The pharmacy advertises its services clearly. And pharmacy team members reach out to the local community to promote health and wellbeing. Pharmacy team members dispense medicines into devices to help people remember to take them correctly. And they manage this service well. They take steps to identify people taking high-risk medicines. And they provide these people with suitable advice to help them take their medicines safely. Pharmacy team members store, source and manage medicines appropriately. And they regularly check the expiry dates of medicines, so they know the medicines are fit to supply.

Inspector's evidence

The pharmacy had level access through two automatic doors. Its services were advertised outside. And the information and the pharmacy's opening hours could be seen when it was closed. The also advertised its services in the retail area. Pharmacy team members explained they would use written communication with people with a hearing impairment. And they could provide people with visual impairment with large print labels. The pharmacy was an accredited Healthy Living Pharmacy (HLP). Pharmacy team members ran a health promotion campaign about a different topic every month. They displayed information about the current topic in various locations around the pharmacy for people to see. They used a variety of different materials, such as posters, wall displays, leaflets, table displays and sometimes balloons and banners. The healthy living champion explained the team tried to make each campaign as bright and memorable for people as possible to help communicate the key messages of each campaign. She explained the topics chosen were aligned with national health promotions campaigns. And others were chosen by the team. Pharmacy team members kept records and photographs of each campaign they ran. A recent example had been a coffee morning to raise awareness of cancer and to raise money for Macmillan. They had advertised the coffee morning in the pharmacy the month before. And the event was well attended by people from the local community. Pharmacy team members explained it had given people the opportunity to ask questions to team members and share their own experiences of cancer with others. Pharmacy team members completed training on each topic before the campaign was launched. The training was provided in different forms. Sometimes pharmacy team members read a briefing pack. Other times they completed online training. They explained this helped them to talk to people about the subjects. And helped them to provide people with the right advice. The healthy living champion said she had plans to develop HLP further in to the local community by using social media. And by running events in the rooms on the first floor of the pharmacy that were currently unused. One idea was a parent and toddler group.

Pharmacy team members signed the dispensed by and checked by boxes on dispensing labels. This was to maintain an audit trail of staff involved in the dispensing process. They used dispensing baskets throughout the dispensing process to help prevent prescriptions being mixed up. The pharmacist counselled people receiving prescriptions for valproate if appropriate. And they checked if the person was aware of the risks if they became pregnant while taking the medicine, giving them appropriate advice and counselling. And they would contact their GP with any concerns. The pharmacy had a supply of printed information available to give to people to help them manage the risks. But the pharmacist was unsure about when to give people the printed material. They gave an assurance that they would refresh their knowledge of the requirements. The pharmacy supplied medicines in multi-compartment

compliance packs when requested. The pharmacy attached backing sheets to the packs, so people had written instructions of how to take their medicines. And these included descriptions of what the medicines looked like, so they could be identified in the packs. Pharmacy team members provided people with patient information leaflets about their medicines each month. They documented any changes to medicines provided in packs on the patient's electronic medication record. The pharmacy delivered medicines to people. It recorded the deliveries made and asked people to sign for their deliveries. The delivery driver left a card through the letterbox if someone was not at home after trying to deliver twice in the same day. And returned the medicines to the pharmacy. The card asked people to contact the pharmacy. The team highlighted bags containing CDs with a sticker on the bag and on the driver's delivery sheet.

The pharmacy obtained medicines from three licensed wholesalers. It stored medicines tidily on shelves. And all stock was kept in restricted areas of the premises where necessary. Pharmacy team members gave a sound explanation of the requirements of the Falsified Medicines Directive (FMD). The pharmacy had the necessary equipment and procedures in place. And pharmacy team members were regularly scanning packs of medicines to check for counterfeits. The pharmacy had adequate disposal facilities available for unwanted medicines, including controlled drugs (CDs). Pharmacy team members kept the CD cabinets tidy and well organised. And, out of date and patient returned CDs were segregated. The inspector checked the physical stock against the register running balance for three products. And they were found to be correct. Pharmacy team members kept the contents of the pharmacy fridge tidy and well organised. They monitored minimum and maximum temperatures in the fridge every day. And they recorded their findings. The temperature records seen were within acceptable limits. Pharmacy team members checked medicine expiry dates every month. And records were seen. They highlighted any short-dated items with a mark on the pack up to 12 months in advance of its expiry. And they recorded expiring items on a monthly stock expiry sheet, for removal in the month before their expiry. The pharmacy responded to drug alerts and recalls. And, any affected stock found was quarantined for destruction or return to the wholesaler. It recorded any action taken. And, records included details of any affected products removed.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the necessary equipment available, which it properly maintains. And it manages and uses the equipment in ways that protect people's confidentiality.

Inspector's evidence

The pharmacy had the equipment it needed to provide the services offered. The resources available included the British National Formulary (BNF), the BNF for Children, various pharmacy reference texts and use of the internet. The pharmacy had a set of clean, well maintained measures available for medicines preparation. It positioned computer terminals away from public view. And, these were password protected. The pharmacy stored medicines waiting to be collected in the dispensary, also away from public view. It had a dispensary fridge that was in good working order. And pharmacy team members used it to store medicines only. They restricted access to all equipment. And, they stored all items securely.

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.