General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Blackstone Pharmacy, 43 Coventry Street, BRADFORD, West Yorkshire, BD4 7HX

Pharmacy reference: 1039427

Type of pharmacy: Community

Date of inspection: 18/01/2023

Pharmacy context

The pharmacy is in a residential area in the suburbs of Bradford. Pharmacy team members dispense NHS prescriptions and sell a range of over-the-counter medicines. They provide medicines to people in multi-compartment compliance packs. And they deliver 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 adequately identifies and manages risks. It has the written procedures it needs relevant to its services. Pharmacy team members generally consider the risks of providing services to people. They understand their role to help protect vulnerable people. And they suitably protect people's confidential information. Team members mostly record and discuss the mistakes they make so that they can learn from them. But they don't always capture key information or analyse these records, so they may miss some opportunities to learn and improve.

Inspector's evidence

The pharmacy had a set of standard operating procedures (SOPs) in place to help pharmacy team members manage the risks. The superintendent pharmacist (SI) had reviewed the SOPs in 2022 and was due to review the SOPs again in 2024. Pharmacy team members had signed to confirm they had read and understood the procedures since the last review. A pharmacist who worked at the pharmacy was an independent prescriber who occasionally provided private prescriptions for people to treat minor illnesses following a face-to-face consultation in the pharmacy. The pharmacist had completed a risk assessment (RA) for their prescribing in June 2021. The RA considered several risks of providing prescriptions for people and briefly detailed the measures the pharmacist had adopted to help mitigate the risks. The pharmacy also had an SOP for minor illness prescribing to help the pharmacist manage the risks. The superintendent pharmacist (SI) explained that prescribing by the pharmacist, who usually worked at the pharmacy once a week, was rare and only usually happened when people were unable to access a prescription elsewhere, for example when they were unable to get an appointment with their GP. The pharmacy provided records of seven consultations that the pharmacist had provided since 2021. The records generally gave sufficient information about each consultation, including the information gathered by the pharmacist to make their clinical assessment. And the decision they had made about whether to prescribe and the treatment provided.

Pharmacy team members highlighted and recorded near miss and dispensing errors they made. There were documented procedures to help them do this effectively. They used this information to make changes to help prevent the same or similar mistakes from happening again. One example of changes they had made was separating look-alike and sound-alike (LASA) medicines, such as amlodipine and amitriptyline, to help prevent the wrong medicines being selected. The records available contained little or no information about why mistakes had been made. Or the changes team members had made to prevent them happening again. Pharmacy team members had also not recorded any near miss errors in November and December 2022, although records were available before and after these months. The SI explained that the pharmacy had been very busy in November and December 2022, and they admitted that mistakes had been made that were not recorded. A dispenser confirmed that although errors had not been recorded, they had still discussed their mistakes and made changes where necessary to help prevent them happening again. The pharmacist looked at the data collected ad hoc to establish any patterns of errors. And they discussed the patterns found with the team. But they did not record their analyses. This meant they might miss opportunities to reflect, learn, and make improvements to the pharmacy's services. The pharmacy had a system in place to manage and record dispensing errors, which were errors identified after the person had received their medicines. The pharmacist explained they had not made any dispensing errors, so there were no completed records to see. This meant the inspector was unable to assess the quality of the pharmacy's response to dispensing errors at this

inspection.

The pharmacy had a documented procedure in place for handling complaints or feedback from people. Pharmacy team members explained feedback was usually collected verbally. And any complaints were referred to the pharmacist to handle. There was information available for people in the retail area about how to provide the pharmacy with feedback. The pharmacy had up-to-date professional indemnity insurance in place. The pharmacy kept accurate controlled drug (CD) registers. These were kept electronically. It kept running balances for all registers, including registers for methadone. But pharmacy team members did not regularly audit these against the physical stock quantity. The inspector checked the running balances against the physical stock for three products, and these were all found to be correct. The pharmacy kept a paper register of CDs returned by people for destruction. It maintained a responsible pharmacist record electronically. There were several gaps in the record. These issues were discussed, and the SI gave their assurance that all records would be updated and properly maintained in future. Pharmacy team members monitored and recorded fridge temperatures daily. They kept private prescription and emergency supply records, which were complete and in order.

The pharmacy kept sensitive information and materials in restricted areas. It segregated confidential waste which was collected for secure disposal. The pharmacy had a documented procedure in place to help pharmacy team members manage sensitive information. Pharmacy team members explained how important it was to protect people's privacy and how they would protect confidentiality. A pharmacy team member gave some brief examples of symptoms that would raise their concerns about vulnerable children and adults. They explained how they would refer to the pharmacist. The pharmacy had a documented procedure for dealing with concerns about children and vulnerable adults. And it displayed information in the pharmacy, including numbers for local safeguarding contacts, to help team members manage any concerns. The SI had completed safeguarding training in 2021. But the pharmacy had not provided any recent training to other team members about how to handle a safeguarding concern.

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 some appropriate, ad-hoc training to help keep their knowledge and skills up to date. Pharmacy team members feel comfortable raising concerns and discussing ways to improve services.

Inspector's evidence

At the time of the inspection, the pharmacy team members present were the superintendent pharmacist (SI) and a qualified dispenser. The SI explained they had recently experienced some problems recruiting and retaining pharmacy team members, and difficulties with staff absences due to illness over the winter period. This had increased pressures on the team. But team members explained they felt they were managing the workload adequately, which was seen during the inspection. The SI explained they were currently recruiting four more team members and had recently appointed two trainee dispensers. Pharmacy team members completed training ad-hoc by reading various materials. And by completing training modules provided by the NHS e-learning for healthcare platform when available. The pharmacy did not have a formal appraisal or performance review process for pharmacy team members. A dispenser explained they would raise any learning needs verbally with the SI. And they were supported by being signposted to relevant reference sources or by discussion to help address their learning needs.

A pharmacy team member explained how they would raise professional concerns with the SI, who worked at the pharmacy regularly. They felt comfortable raising concerns. And confident that their concerns would be considered, and changes would be made where they were needed. The pharmacy did not have a formal whistleblowing policy. Pharmacy team members were aware of organisations outside the pharmacy where they could raise professional concerns, such as the NHS or GPhC. Pharmacy team members communicated with an open working dialogue during the inspection. The pharmacy owners did not ask pharmacy team members to meet any performance related targets.

Principle 3 - Premises ✔ Standards met

Summary findings

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

Inspector's evidence

The pharmacy was clean and well maintained. It was tidy and generally well organised. The pharmacy's floors and passageways were mostly free from clutter and obstruction. But some areas were cluttered with totes of medicines waiting to be put away. The SI explained the totes did not usually accumulate, but a team member was absent because of illness causing a delay unpacking the medicines order. The pharmacy kept equipment and stock on shelves throughout the premises. It had a first floor which pharmacy team members used for storage and to prepare multi-compartment compliance packs. And it had a private consultation room. Pharmacy team members used the room to have private conversations with people.

The pharmacy had a clean, well-maintained sink in the dispensary used for medicines preparation. It had a toilet, with a sink which provided hot and cold running water and other facilities for hand washing. The pharmacy maintained its heating and lighting to acceptable levels. Its overall appearance was professional, including the pharmacy's exterior which portrayed a healthcare setting. The pharmacy's professional areas were well defined by the layout and were signposted from the retail area. Pharmacy team members prevented access to the restricted areas of the pharmacy.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy supplies medicines to people safely. It has processes in place to help people manage the risks of taking high-risk medicines. It sources its medicines appropriately. The pharmacy adequately manages its medicines. But team members don't always fully record when they check the expiry dates of medicines, which increases the risks of sections of stock being missed.

Inspector's evidence

The pharmacy had level access from the street. Pharmacy team members could use the patient medication record (PMR) system to produce large-print labels to help people with visual impairment. And they said they would use written communication with someone with hearing impairment to help them access services. Pharmacy team members could speak Urdu, as well as English, to help communicate with people in the local community.

Pharmacy team members signed the 'dispensed by' and 'checked by' boxes on dispensing labels during dispensing. This was to maintain an audit trail of the people 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 they were at risk. And they checked if the person was aware of the risks if they became pregnant while taking the medicine. They advised they would also check if they were on a pregnancy prevention programme and taking regular effective contraception. The pharmacy had stock of some information materials to give to people to help them manage the risks of taking valproate. The pharmacist did not record these conversations with people to help with future queries. And the pharmacy did not carry out any regular audits to help identify people at risk.

The pharmacy supplied medicines in multi-compartment compliance packs to care and nursing homes. And to people in their own homes when requested. It attached backing sheets or labels to the packs, so people had written instructions of how to take their medicines. Pharmacy team members included some descriptions of what the medicines looked like, so they could be identified in the packs. They provided care homes with patient information leaflets about peoples medicines every three months. And they provided leaflets when a medicine was newly prescribed. They also provided people in their own homes with leaflets each month. Pharmacy team members documented any changes to medicines provided in packs on the patient's electronic medication record, and on the person's master record sheet, which was a record of all their medicines and the times of administration.

The pharmacy delivered medicines to people. It recorded the deliveries made using an electronic system, which populated information about each delivery run on the delivery driver handheld device. The system provided team members with real-time tracking information and records about each delivery, which helped them deal with delivery queries while the driver was still on their delivery route. The delivery driver left a card through the letterbox if someone was not at home when they delivered. The card asked people to contact the pharmacy. Pharmacy team members highlighted bags containing controlled drugs (CDs) to the driver and annotated their delivery record to help make sure the item was not missed.

The pharmacy obtained medicines from licensed wholesalers. It had disposal facilities available for

unwanted medicines, including CDs. Team members monitored the minimum and maximum temperatures in the pharmacy's fridge each day and recorded their findings. The temperature records seen were within acceptable limits. The pharmacy had a documented procedure for checking stock for short-dated and expired medicines. The procedure had been updated and read by pharmacy team members since the last inspection. And it instructed team members to carry out check each month. The last recorded full check had been completed in September 2022. Team members explained that checks had been carried out since but had not been recorded. They highlighted short-dated medicines up to three months before their expiry and recorded these items on a monthly stock expiry sheet, for removal at the beginning of their month of expiry. Records were seen, and these confirmed that checks had been completed but had not been recorded on the checking log. After a search of the shelves, the inspector did not find any out-of-date medicines. But some shelves were untidy and cluttered, which increased the risks of mistakes being made by people selecting the incorrect item when dispensing. The SI explained the shelves were usually tidier, but recent staff absences had caused the team to fall behind with their usual tidying activities. The SI provided their assurance that the shelves would be tidied and organised properly as soon as possible when team members returned to work.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the necessary equipment available for the services it provides. It manages and uses its 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 it had 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 had suitable containers available to collect and segregate its confidential waste. It kept its password-protected computer terminals and bags of medicines waiting to be collected in the secure areas of the pharmacy, away from public view.

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.