General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: R. Chemist, 7 The Square, Lower Grange, BRADFORD, West Yorkshire, BD8 0QB

Pharmacy reference: 1039484

Type of pharmacy: Community

Date of inspection: 22/01/2020

Pharmacy context

This is a community pharmacy on a parade of shops in the city of Bradford, West Yorkshire. It dispenses both NHS and private prescriptions and sells a range of over-the-counter medicines. The pharmacy team offers advice to people about minor illnesses and long-term conditions. It provides NHS services, such as the New Medicines Service (NMS) and medicines use reviews (MURs). The pharmacy supplies medicines in multi-compartment compliance packs to people living in their own homes. And it provides a home delivery service to people who have difficulty collecting their medicines from the pharmacy.

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 mostly identifies and manages the risks associated with the services it provides to people. And it has a set of written procedures for the team members to follow to help them work effectively. The pharmacy generally keeps the records it must have by law. And it keeps people's private information secure. The team members know when and how to raise a concern to help safeguard the welfare of vulnerable adults and children. The team members openly discuss mistakes that they make when dispensing. But they do not keep up-to-date records of these mistakes. And so, they may miss out on the opportunity to learn from them and reduce the risk of similar mistakes happening again.

Inspector's evidence

The pharmacy had a set of standard operating procedures (SOPs) in place. The SOPs did not have an index, which made it difficult to find a specific SOP. They were scheduled to be reviewed every two years. The pharmacist explained how he had reviewed them in February 2019 but there was no evidence to confirm this. The pharmacy defined the roles of the pharmacy team members in each procedure. Which made clear the roles and responsibilities within the team. The team members had read and signed each SOP that was relevant to their role. But many of them had done this several years prior to the latest review.

The pharmacist highlighted near miss errors made by the team when dispensing. There was a paper near miss log that the team could use to record the details of each near miss error. But it was not used particularly often. The pharmacist explained as the pharmacy team was small, the team members found it more beneficial to discuss the near misses with each other when they happened. And discuss ways they could prevent a similar error from happening again. The team members scanned the barcodes of each medicine they dispensed. And the dispensing software would alert the team member if they had selected the incorrect item. The system had greatly reduced the number of near miss errors the team were making. The pharmacist had created some laminated alert posters to attach next to medicines that had similar names to others (LASAs). For example, indapamide and imipramine. The posters were designed to remind the team members to double check they had selected the right medicine. The pharmacy had a basic process to handle dispensing incidents that had reached the patient. But the pharmacy did not keep any records for future reference and learning. The pharmacist handled any incidents. Most recently, the pharmacy had handed out some medicines to the wrong person. The team members held a short discussion about what they could do to prevent a similar incident happening again. They decided they would make sure they always double-checked people's names and addresses against the prescription. And they would change the way they asked the person collecting the medicines to confirm their name and address. For example, they would ask ‘What is your name and address?’ rather than, ‘Is your name and address...?’.

The pharmacy displayed the correct responsible pharmacist notice. So, people in the retail area could see the identity and registration number of the responsible pharmacist on duty. The team members explained their roles and responsibilities. And they were seen working within the scope of their role throughout the inspection. The team members accurately described the tasks they could and couldn’t do in the absence of a responsible pharmacist. For example, they explained how they could only hand out dispensed medicines or sell any pharmacy medicines under the supervision of a responsible pharmacist.

The pharmacy had copies of its practice leaflet available for people to select and take away with them. There was a small section in the leaflet which encouraged people to comment on the service the pharmacy provided. And to make suggestions on how it could improve. The pharmacy collected feedback each year through questionnaires that were placed on the pharmacy counter for people to self-select and complete. After some suggestions from people who used the pharmacy, the pharmacist installed a wall display which held many healthcare related leaflets for people to select and take away with them. The pharmacist explained he had noticed an increase in the number of people who were taking leaflets away with them.

The pharmacy had up-to-date professional indemnity insurance. Entries in the responsible pharmacist record complied with legal requirements. The pharmacy kept complete records of private prescription and emergency supplies. The pharmacy kept controlled drugs (CDs) registers. And they were completed correctly. The pharmacy team members checked the running balances against physical stock each time new stock arrived, or a CD was dispensed. And every three to four months they completed a full balance check of all the pharmacy's CDs. A physical balance check of three random CDs matched the balance in the register. The pharmacy held both electronic and paper form CD registers. The paper registers were held loosely. There wasn't a system to help understand if a register was held in paper form or electronically. And so, it was difficult to find a specific register. The inspector discussed the importance of keeping up-to-date and organised CD registers. The pharmacy kept complete records of CDs returned by people to the pharmacy. The pharmacy held certificates of conformity for unlicensed medicines, but they were not completed in line with the requirements of the Medicines & Healthcare products Regulatory Agency (MHRA).

The pharmacy outlined how it handled personal and sensitive data through a privacy notice in the retail area. The team members had not undertaken any training on General Data Protection Regulation (GDPR). But they were aware of the need to keep people's personal information confidential. 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 periodically destroyed via a shredder.

The pharmacist had completed training on safeguarding vulnerable adults and children through the Centre for Pharmacy Postgraduate Education (CPPE). When asked about safeguarding, the team members gave several examples of the symptoms that would raise their concerns in both children and vulnerable adults. The pharmacy assistant explained how she would discuss her concerns with the pharmacist on duty, at the earliest opportunity. The pharmacy had some basic written guidance on how to manage or report a concern and the contact details of the local support teams.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy team members have the appropriate qualifications and skills to provide the pharmacy's services safely and effectively. They work well together to manage their workload. And they feel comfortable to raise professional concerns when necessary. The pharmacy provides its team members with training modules to help them keep their knowledge and skills refreshed and up to date.

Inspector's evidence

The pharmacist on duty was the pharmacy's owner and superintendent pharmacist. He was supported by three full-time NVQ level two qualified pharmacy assistants. The pharmacy also employed a delivery driver and two part-time NVQ level two qualified pharmacy assistants. They were not working during the inspection. The team members were observed managing the workload well and had a manageable workflow. The team members were seen asking the pharmacist for support, especially when presented with a query for the purchase of an over-the-counter medicine. They acknowledged people as soon as they arrived at the pharmacy counter. The team members often worked additional hours to cover absences and holidays. The team members did not take holidays in the run up to Christmas to make sure the pharmacy had enough team members working, as this was the busiest time of the year for the pharmacy. And the team members made sure that no more than one of them was absent at any one time.

The pharmacy did not provide its team members with a structured training programme to help them keep their knowledge and skills up-to-date. The pharmacy had a tablet computer which was provided to them by an external contractor. The tablet contained a library of modules and training programmes which the team members could choose to work through. The tablet held records of any training modules that had been completed. A team member had planned to complete a module on eczema and skincare in the next few weeks.

The team members occasionally held team meetings and aimed to hold them on a day when all the team members were working. The meetings were an opportunity for the team members to discuss any issues and ways in which they could improve the quality of the service the pharmacy was providing to people. Most recently, the team members had asked the pharmacist to install a new computer terminal at the back of the dispensary. This was to help them dispense prescriptions without distractions from the retail area.

The team members felt comfortable to raise professional concerns with the pharmacist. The pharmacy did not have a whistleblowing policy. And so, the team members couldn't raise concerns anonymously. The team was not set any targets to achieve.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are secure and well maintained. And suitable for the services the pharmacy provides. The pharmacy has a sound-proofed room where people can have private conversations with the pharmacy's team members.

Inspector's evidence

The pharmacy premises were spacious and suitable for the services provided. It was clean and professional in its appearance. The building was easily identifiable as a pharmacy from the outside. There was an open plan dispensing area which had plenty of bench space and storage for medicines. The benches were generally untidy, but this improved as the inspection progressed. There were rooms on the first-floor of the building which was used for the storage of excess stock and some miscellaneous items.

Floor spaces were mostly kept clear to minimise the risk of trips and falls. But some boxes of medicines were stored on the floor. There was a clean, well-maintained sink in the dispensary for medicines preparation and staff use. There was a staff toilet with hot and cold running water and other facilities for hand washing. There was a sink in the staff area used for drink and food preparation. The pharmacy had a sound-proofed consultation room with seats where people could sit down with a team member. It was kept tidy and portrayed a professional image. The room was signposted by a sign on the door. The temperature was comfortable throughout the inspection. Lighting was bright throughout the premises.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's services are accessible to people. And the pharmacy mostly manages its services appropriately and delivers them safely. The pharmacy sources its medicines from licenced suppliers and it appropriately stores them. It supports some people by providing their medicines in multi-compartment compliance packs to help them take them correctly. But it doesn't provide these people with all the information they may need about their medicines. The pharmacy has some safeguards in place to provide a safe and effective home delivery service. But it doesn't ask people to sign for receipt of their medicines. So, the team may not be able to effectively answer any queries.

Inspector's evidence

The pharmacy was accessible via a step from the street to a simple push/pull entrance door. The pharmacy had a portable ramp that people with prams or wheelchairs could use to access the building. There were several car parking spaces outside the pharmacy. The pharmacy advertised its services and opening hours in the main window. The team had access to the internet to direct people to other healthcare services. The team members could provide people with a visual impairment with large print dispensing labels.

The team members recorded short notes on prescriptions, and they used these 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 when the dispensing process was complete. But the pharmacist did not sign the labels to confirm he had completed a final accuracy and clinical check. And so, a full audit trail of the dispensing process was not in place. They used baskets to hold prescriptions and medicines to reduce the risk of errors. They wrote ‘CD’ in small triangle to highlight prescriptions for a CD that was not required to be stored in the CD cabinet. This system helped the team members check the date of issue of the prescription and helped prevent them from handing out any CDs to people after their prescription had expired. 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 kept records of the delivery of medicines it made to people. The records did not include a signature of receipt. So, there was no audit trail that could be used to solve any queries.

The pharmacy supplied medicines in multi-compartment compliance packs for people living in their own homes. And the pharmacy supplied the packs to people on either a weekly or monthly basis. In most instances the patient was responsible for ordering their own prescriptions. The pharmacy sent text message reminders to people on the second or third week of their four-week cycle to remind them to order their prescriptions. If the team members felt a person was unable to order their own prescriptions, they asked for permission from the person’s GP surgery to allow them to order their prescriptions for them. This was mainly if a person was suffering from a condition such as dementia. And so, there was a risk they would not remember to order their prescriptions on time. They dispensed the packs in a room on the first floor of the building. This was to minimise distractions. The pharmacy managed the workload across four weeks. The pharmacy kept master sheets which recorded the person's current medication and times of administration. The team members used these to check off prescriptions and confirm they were accurate. They supplied the packs with information which listed

the medicines in the packs and the directions. But they did not give people any information help them visually identify the medicines. For example, the colour or shape of the tablet or capsule. So, it may be difficult for them to identify individual medicines in case of a query. And they did not provide people with patient information leaflets with the packs. This was not in line with requirements.

The pharmacy dispensed high-risk medicines for people such as warfarin, lithium and methotrexate. The pharmacist explained he did some basic checks with people when they came to collect their medicines. These included ensuring the person had had a recent blood test and checked their current and target INR if they were prescribed warfarin. The team members were aware of the pregnancy prevention programme for people who were prescribed valproate and of the risks. They demonstrated the advice they would give people in a hypothetical situation. And there was a poster displaying information about the programme attached to a dispensary wall. The team members had access to literature about the programme that they could provide to people to help them take their medicines safely.

Pharmacy medicines were stored behind the pharmacy counter. Which prevented people from self-selecting the medicines. Every three months, the team members checked the expiry dates of its medicines to make sure none had expired. But the team were unable to locate any records of the process having been completed since October 2019. No out-of-date medicines were found after a random check of around twenty medicines. The team members did not always record the date liquid medicines were opened on the pack. So, they couldn't always check they were in date and safe to supply. The pharmacy had a robust procedure in place to appropriately store and then destroy medicines that had been returned by people.

The team was scanning products and undertaking manual checks of tamper evident seals on packs, as required under the Falsified Medicines Directive (FMD). The team had received some basic training on how to follow the directive. It had the correct type of scanners and software installed. Drug alerts were received via email to the pharmacy and actioned. The team kept a record of the action it had taken following the alert. The team checked and recorded the fridge temperature ranges generally every day. And a sample checked were within the correct ranges. But the temperature had not been recorded for the four days prior to the inspection. The temperature was in range when checked during the inspection. The CD cabinets were secured and of an appropriate size. The medicines inside the fridge and CD cabinets were well organised.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy's equipment is well maintained and appropriate for the services it provides. The pharmacy mostly uses its equipment and facilities 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 members used tweezers and rollers to help dispense multi-compartment compliance packs. The fridges used to store medicines were of an appropriate size.

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 unauthorised 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. But some confidential material, for example service consent forms, were kept in plain sight in the consultation room. And so, there was a risk that people's confidentiality may be compromised. This was discussed with the team. And the pharmacist explained he would plan to remove the confidential information from the room following the inspection.

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.