General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Shelf Pharmacy, 14 Carr House Road, Shelf, HALIFAX, West Yorkshire, HX3 7QY

Pharmacy reference: 1039541

Type of pharmacy: Community

Date of inspection: 06/10/2022

Pharmacy context

The pharmacy is in a parade of shops in Shelf, near Halifax. 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. The pharmacy provides a Covid-19 and seasonal flu vaccination service to people.

Overall inspection outcome

Standards not all met

Required Action: Improvement Action Plan

Follow this link to find out what the inspections possible outcomes mean

Summary of notable practice for each principle

Principle	Principle finding	Exception standard reference	Notable practice	Why
1. Governance	Standards not all met	1.1	Standard not met	The pharmacy doesn't adequately manage all the risks with its services. This includes pharmacy team members working in an untidy and cluttered dispensary. And there is an increased risk of mistakes by the way the pharmacy stores and manages its medicines. The pharmacy doesn't have complete and up-to-date written procedures that reflect the pharmacy's current practice. Team members do not always follow the procedures. And some team members have not read them.
		1.2	Standard not met	Pharmacy team members do not have robust arrangements to learn from mistakes. They do not record or analyse their mistakes. And they do not routinely make changes to their practices to help make the pharmacy's services safer.
2. Staff	Standards met	N/A	N/A	N/A
3. Premises	Standards not all met	3.1	Standard not met	The pharmacy is cluttered and untidy. Pharmacy team members do not use the limited space available efficiently. And some areas have insufficient lighting. This introduces significant unnecessary risks.
4. Services, including medicines management	Standards not all met	4.3	Standard not met	The pharmacy does not have adequately robust processes for managing and storing its medicines, including checking expiry dates. And there is evidence of out-of-date medicines on the shelves. The pharmacy does not always store medicines prepared in multi-compartment compliance packs safely. So, there is a risk it may supply medicines to the wrong person. And it does not keep all its medicines in the original packs, increasing the risk of errors.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance **Standards not all met**

Summary findings

The pharmacy doesn't have adequate governance arrangements in place to identify and manage all the risks associated with its activities. It has some documented procedures it needs relevant to its services, but some key procedures are missing. Pharmacy team members don't always follow the procedures. And some team members have not read them. Team members sometimes discuss mistakes they make in the dispensing process. But they don't record their mistakes or routinely make changes to prevent mistakes happening again. So, they may miss opportunities to learn and make services safer. Pharmacy team members suitably protect people's confidential information. And they keep the records they must by law.

Inspector's evidence

The pharmacy had a set of standard operating procedures (SOPs) in place. It stored these procedures electronically on the pharmacy's main computer terminal. The desktop folder where the SOPs were kept included current SOPs and older SOPs that had been reviewed. This made it difficult for people to determine which were the most recent and up-to-date procedures to follow. The superintendent pharmacist had reviewed some of the SOPs in 2021 and 2022. But some of the procedures seen had not been reviewed since 2019. The pharmacy did not have any records available to confirm that pharmacy team members had read and understood the written procedures. The pharmacy also had two trainee team members who had started working at the pharmacy since 2021. They confirmed they had not read the SOPs since they had started working at the pharmacy. Some of the ways of working in the pharmacy did not match the SOPs and introduced risk. These included the way team members responded to near-miss and dispensing errors, how they managed controlled drugs registers, and how they managed checking medicines expiry dates. Several of the pharmacy's benches where prescriptions were prepared were cluttered and untidy. Much of the clutter was caused by stacks of baskets containing prescriptions at various stages of the dispensing process. One dispenser was seen using a tote bin to simultaneously dispense prescriptions for two people living at the same address. This was discussed and they explained they sometimes did this because there was not enough bench space to use instead. This increased the risks of a near-miss or dispensing errors being made.

The pharmacy had a documented procedure available about how to handle near miss errors made by pharmacy team members while dispensing. But team members were not following the procedure. Pharmacy team members sometimes recorded their near miss errors on a paper record. And they sometimes thought about how to be more careful while they dispensed. But they could not provide any examples of any changes they had made to make things safer after they had made an error. The most recent record available during the inspection had been made in June 2021. Team members could not find any more recent records. They admitted they did not record all their mistakes. And the records they did make provided little or no information about why mistakes had been made. Or the actions they had taken to prevent a recurrence and aid future learning. Pharmacy team members did not analyse the errors they made to look for patterns. The pharmacy had a written procedure to help team members manage and record dispensing errors, which were errors identified after the person had received their medicines. But the procedure was not being followed, as a recent error had been recorded as brief handwritten notes. The SI explained they had discussed the error with the team to make them aware of the incident. But team members had not made any specific changes to help prevent the same or a similar mistake happen again. The pharmacy did not have any systems in place to

effectively record all the necessary details of dispensing errors. Or to be able to recall and reflect on errors they had made previously. This meant they may miss opportunities to learn and make the pharmacy's services safer.

The pharmacy established a Covid-19 vaccination service during phase 3 of the national vaccination programme in 2021. And it continued to provide Covid-19 vaccinations to people. The pharmacy used the national patient group direction (PGD) as the legal framework for its pharmacists to administer vaccinations to people. The SI had completed a risk assessment before providing the service. But they had not updated the assessment since the service began and could not find the risk assessment document during the inspection. The SI explained they had changed the way they delivered the service in response to challenges that had emerged. One example had been streamlining the pharmacy's processes for booking people in when they arrived for the vaccinations and completing screening questionnaires. The pharmacy was also providing a seasonal flu vaccination service to people. It had up-to-date PGD documents in place, but these had not been signed by the SI or the pharmacists delivering the vaccinations. The pharmacists had been trained to provide flu vaccinations. The SI had not completed a risk assessment specifically for the flu vaccination service. They explained they were confident that the steps they had implemented to minimise the risks of providing the Covid-19 vaccination service were sufficient to be able to manage the risks of providing flu vaccinations. But agreed that it may be necessary to consider some risks that only applied to the flu vaccination service.

The pharmacy had a documented procedure to deal with complaints handling and reporting. It collected feedback from people using questionnaires. And it displayed the results of its latest batch of questionnaires that had been analysed. Pharmacy team members explained they had received feedback about the length of time it took them to respond to someone when they arrived in the pharmacy. So, they were now making a dedicated effort to break off from their tasks to acknowledge, and often serve, someone as soon as they came in. This included breaking off from preparing prescriptions. They acknowledged this could increase the risk of errors but as they had not regularly been recording near miss errors, the pharmacy had no information available to determine the impact of these changes. The pharmacy had up-to-date professional indemnity insurance in place. The pharmacy kept controlled drug (CD) registers, but these were not well organised. It kept running balances in all registers. But pharmacy team members did not regularly audit these balances. And several registers were loose and were not secured in folders with the other registers. This increased the risks of CD registers being lost. The pharmacy kept a register of CDs returned by people for destruction. It maintained a responsible pharmacist record. And this was complete and up to date. The pharmacist displayed their responsible pharmacist notice to people. Pharmacy team members monitored and recorded fridge temperatures daily.

The pharmacy kept sensitive information and materials in restricted areas. It segregated and secured confidential waste. And this was collected for secure destruction each month by a waste disposal contractor. Pharmacy team members explained how they protected people's privacy and confidentiality. The pharmacy did not have a documented procedure about confidentiality and data protection available in the pharmacy to help them achieve this. Pharmacy team members gave some examples of signs that would raise their concerns about vulnerable children and adults. They explained how they would refer their concerns to the pharmacist. But some team members were unsure about how to identify a safeguarding concern in vulnerable adults and children. And they were unsure about who else they could contact outside the pharmacy to seek help or refer their concerns to. The SI explained they had completed safeguarding training recently, along with the pharmacy technician and a medicines counter assistant to comply with the requirements of a recent NHS Pharmacy Quality Scheme (PQS). But they could not find any training records and where unsure when their training had been completed. Other pharmacy team members had not completed training and there was no SOP

available to help them manage 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 training to keep their knowledge up to date. Pharmacy team members feel comfortable discussing ideas and issues. And they sometimes make effective changes to improve their environment and the way they work.

Inspector's evidence

At the time of the inspection, the pharmacy team members present were the superintendent pharmacist (SI), a pharmacy technician, two dispensers, a trainee dispenser, and a delivery driver. Pharmacy team members completed training ad hoc by reading various materials and discussing topics together. They explained they had not had time to complete any training since before the Covid-19 pandemic started in March 2020. The pharmacy did not have an appraisal or performance review process for team members. Team members explained they would raise any learning need informally with the pharmacist or SI, who would teach them or signpost them to appropriate resources.

Pharmacy team members felt comfortable sharing ideas to improve the pharmacy's services. Following a discussion, the pharmacy had changed its staffing profile after a medicines counter assistant (MCA) had left. Initially, the remaining team members were managing the work that had been done by the (MCA). But this had put extra pressure on the team. They discussed their concerns with the SI who agreed to recruit a new MCA to help relieve the extra pressure placed on the rest of the team. Pharmacy team members explained they would raise professional concerns with the pharmacist or SI. They felt comfortable raising concerns. And confident that concerns would be considered, and changes would be made where they were needed. The pharmacy did not have a whistleblowing policy, and team members were unsure about how to raise concerns anonymously. This was discussed, including where team members could raise their concerns outside their organisation, such as the GPhC or the NHS.

Principle 3 - Premises **Standards not all met**

Summary findings

The pharmacy's premises are generally suitable for the services it provides. But it has an area where there is insufficient lighting. And the areas where team members prepare prescriptions are cluttered and untidy, creating risks. Pharmacy team members do not use the limited space available in the most efficient way to help minimise these risks. The pharmacy has a suitable room where people can speak to pharmacy team members privately.

Inspector's evidence

The areas of the pharmacy where prescriptions were prepared were untidy. The benches were cluttered with paperwork and baskets containing prescriptions and medicines at various stages of the dispensing process. The pharmacy had a limited amount of bench space for team members to use to prepare prescriptions. And team members were not using the available space efficiently. The floors and passageways were generally free from clutter and obstruction. But there was a room on the first floor where team members prepared multi-compartment compliance packs. And here, team members were storing baskets of prescriptions, medicines, and compliance packs on the floor. The area where packs were prepared was generally tidy. But the area was dimly lit which made it difficult to read prescriptions and clearly see the medicines being dispensed, including expiry dates on packaging. The pharmacy stored completed packs in large totes, which were kept on shelves in a storage area on the first floor. These totes were very full. And this increased the risks of someone being supplied with a pack that belonged to someone else. The first-floor storage area was cluttered and untidy. And this made it difficult to access items stored on the shelves, such as compliance packs and excess stock.

The pharmacy's retail area was tidy, well organised, and brightly lit. It had a private consultation room available. Pharmacy team members used the room to have private conversations with people. There was a clean, well-maintained sink in the dispensary used for medicines preparation. There was a toilet, with a sink which provided hot and cold running water and other facilities for hand washing. The pharmacy's overall appearance to the public was professional, including the pharmacy's exterior which portrayed a professional healthcare setting. The pharmacy's professional areas were well defined by the layout and were well signposted from the retail area. Pharmacy team members prevented public access to the restricted areas of the pharmacy.

Principle 4 - Services **Standards not all met**

Summary findings

The pharmacy sources its medicines from reputable suppliers. But it does not always store and manage its medicines appropriately. The pharmacy does not have a robust process for checking the expiry date on medicines. And it does not always keep its medicines in the original packs. So, it may not be able to adequately ensure the safety of its medicines. Pharmacy team members provide some people with advice and information about high-risk medicines. But they do not always routinely provide people with written information to help them take and manage their medicines safely.

Inspector's evidence

The pharmacy had stepped access from the street. It had a bell for people to use to attract attention if they needed help accessing the premises. Pharmacy team members could use the patient medication record (PMR) system to produce large-print labels to help people with visual impairment. They explained how they would use written communication to help people with a hearing impairment. The pharmacy offered over-the-counter medicines and other products to people via its website, www.shelfpharmacy.co.uk. All supplies to people made via the website were provided by a third-party contractor.

The pharmacy had a documented procedure for checking stock for short-dated and expired medicines, which had been reviewed by the superintendent pharmacist in 2022. But this did not match the process being carried out by pharmacy team members. And team members did not know when they had last read the current standard operating procedure (SOP). The pharmacy did not have any records available of any expiry date checking being completed. When questioned, a dispenser explained that team members completed date checking approximately every six months. And some sections had been checked recently. But these checks had not been recorded. And team members could not confirm which areas they had checked and which they had not. Pharmacy team members highlighted medicines that were due to expire by attaching a sticker to the pack. They attached stickers if the medicine was due to expire before the next scheduled check. But there were no records available to confirm when the next scheduled date check would be. Team members confirmed they would remove expiring items during their month of expiry. But this relied on them seeing a sticker on the packs when they looked at the shelves. After a search of the shelves, the inspector found five expired medicines with various expiry dates from March 2022 onwards. Four of these packs had not been highlighted with a sticker as being short dated.

Several boxes were found on the pharmacy's shelves that contained mixed batches of medicines. These were medicines that displayed a batch number and expiry date that did not match the details printed on the outer container. One example of this was a box of carbocisteine capsules. The box displayed an expiry date of March 2025. But some of the strips inside were due to expire in January 2025. This meant there was a risk of people dispensing these capsules after they expired and before the box was removed from the shelves. Another example was a box of codeine phosphate 15mg tablets that contained several foil strips of tablets that had been cut during dispensing. Several of these strips displayed a batch number and expiry that did not match the packaging. Some strips did not display any batch number or expiry date. And two strips, that also did not display any batch number or expiry, were codeine phosphate 30mg tablets. This meant there was a risk of people dispensing the incorrect strength of codeine phosphate. And a risk these medicines would not be identified in the event of a

manufacturers recall.

The pharmacy supplied medicines to people in multi-compartment compliance packs when requested. It attached backing sheets to the packs, so people had written instructions of how to take their medicines. Pharmacy team members included descriptions of what the medicines looked like, so they could be identified in the pack. But they did not routinely provide people with patient information leaflets about their medicines each month. They only provided leaflets to people when their medicines were newly prescribed. Once prepared, the pharmacy stored completed packs in totes according to the day of the week they were due to be supplied, meaning different people's packs were stored together. Packs were placed in the totes in a random order and the totes were very full. This increased the risks of someone receiving someone else's pack. Packs were also stored without their relevant prescriptions. This meant it would be difficult to complete any further checks or resolve future queries. Pharmacy team members documented any changes to medicines provided in packs on the person's master record sheet, which was a record of all their medicines and where they were placed in the packs. And they recorded changes on their electronic patient medication record (PMR).

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. They also checked if the person was on a pregnancy prevention programme. The pharmacy delivered medicines to people, and it recorded the deliveries it made. 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. The pharmacy obtained medicines from licensed wholesalers. It stored medicines on shelves, and it kept all stock in restricted areas of the premises where necessary. The pharmacy had adequate disposal facilities available for unwanted medicines, including CDs. Pharmacy team members monitored the minimum and maximum temperatures in the fridge where medicines were stored each day, and they recorded their findings. The temperature records seen were within acceptable limits.

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 the security of people's private information.

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 secure facilities to collect confidential waste. And it kept its password-protected computer terminals 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.