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: 29/06/2023

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 some medicines to people in multi-compartment compliance packs. And they deliver medicines to people's homes. The pharmacy provides a seasonal flu vaccination service to people.

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 associated with its services. And it has documented procedures to help make sure the team provide services effectively. Pharmacy team members understand their role in helping to protect vulnerable people. And they suitably protect people's private information. They record and discuss the mistakes they make so that they can learn from them. And they use this information to make changes to help improve the safety of their services.

Inspector's evidence

The pharmacy had a set of standard operating procedures (SOPs) in place to help pharmacy team members manage risks. The superintendent pharmacist (SI) had reviewed the SOPs in January 2023. The SOPs were easily available to pharmacy team members electronically, and printed copies were also available. All pharmacy team members had read the SOPs in 2023 and had signed the printed copies to confirm their understanding.

The pharmacy provided a busy seasonal flu vaccination service which was due to start again in autumn 2023. The SI explained how they had already started to consider the risks of delivering the service over the coming season, alongside their regular locum pharmacist who helped to deliver the pharmacy's services. These risks included how to manage the popular walk-in element of the service, where people could be vaccinated without an appointment. The SI explained that the pharmacy's current workload pressures would mean it might be difficult to provide a walk-in service safely every day. But they still wanted to be able to provide the local community with a service they needed in a way they had come to expect. So, they were considering operating walk-in vaccinations two days a week to coincide with the days the locum pharmacist worked at the pharmacy, providing two pharmacists to be able to manage vaccinations and the rest of the pharmacy's services. This also meant the days would coincide with the working days of a newly appointed medicines counter assistant, who would be able to help organise people arriving for a vaccination. And this would reduce distractions to team members operating the pharmacy's other services, such as prescription dispensing.

Pharmacy team members highlighted and recorded near miss errors and dispensing errors, which were errors identified after the person had received their medicines. There were documented procedures to help team members do this effectively. They discussed any errors and why they might have happened. And they used this information to make some changes to help prevent the same or similar mistakes from happening again. For example, team members described how they had recently separated the look-alike and sound-alike (LASA) products Gluco Rx Nexus and Gluco Rx Q blood glucose testing strips on the shelves to help prevent the wrong product being selected. Pharmacy team members did not always record enough information about why the mistakes had been made or the changes they had made to prevent a recurrence to help aid future learning. But they gave their assurance that these details were always discussed. The SI or the pharmacy technician analysed the data collected every month to look for patterns. They recorded their analysis and discussed their findings with the team.

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 how they were providing medicines to someone in multi-compartment compliance packs. Team

members had discussed the feedback and adjusted how packs were provided to help ensure they could better accommodate the person's needs to help prevent them missing doses of their medicines.

The pharmacy had up-to-date professional indemnity insurance in place. The pharmacy kept accurate controlled drug (CD) registers. It kept running balances for all registers, including registers for methadone. Pharmacy team members audited these balances against the physical stock quantity when they received medicines in the pharmacy. But this meant that the team did not regularly audit registers for CDs that were not often used. Checks of the running balances against the physical stock for three products were found to be correct. The pharmacy kept a register of CDs returned by people for destruction. It maintained a responsible pharmacist record electronically, which was complete and up to date. The pharmacist displayed their responsible pharmacist notice. Pharmacy team members monitored and recorded fridge temperatures. The pharmacy 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 and secured confidential waste. And this was collected for secure destruction regularly by a waste disposal contractor. Pharmacy team members explained how they protected people's privacy and confidentiality. And the pharmacy had a documented procedure about confidentiality and data protection available to help the team 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. The SI explained they had completed safeguarding training in 2022, along with the pharmacy technician. Other pharmacy team members had not completed formal safeguarding 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 some appropriate training to keep their knowledge up to date. Pharmacy team members feel comfortable discussing ideas and issues. And they use feedback to 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) who was also the responsible pharmacist, a pharmacy technician, two dispensers and a delivery driver. Pharmacy team members completed training ad hoc by reading various materials and discussing topics together. 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. A qualified dispenser had recently started working at the pharmacy. The SI actively encouraged the dispenser to look at the way the pharmacy was operating. And to identify areas for improvement and make suggestions to help improve the pharmacy processes and services. The dispenser explained they were comfortable providing this sort of feedback to the SI and felt encouraged to be honest and share their experiences of working elsewhere. One recent example had been a change to help improve the way the pharmacy ordered and tracked prescriptions for people. 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 had a whistleblowing policy, and team members were clear about how to raise concerns anonymously.

Principle 3 - Premises ✔ Standards met

Summary findings

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

Inspector's evidence

The pharmacy was clean and well maintained. Its area for preparing prescriptions on the ground floor was small and had a limited amount of bench space for team members to use. Team members generally kept these benches tidy and well organised to help maximise the space they had available. The pharmacy had a first floor, which team members used for storage. And there was an area which team members used to prepare and check multi-compartment compliance packs. The pharmacy's floors and passageways were free from clutter and obstruction. The pharmacy kept equipment and stock on shelves throughout the premises. But there were some areas where team members could improve their general organisation to help them make the most efficient use of the space available.

The pharmacy had a private consultation room, which was clearly signposted, and 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 staff toilet, with a sink with hot and cold running water and other hand washing facilities. The pharmacy kept its heating and lighting to acceptable levels, and it had recently installed new lighting on the first floor to help improve the working environment for team members. Its overall appearance was professional and suitable for the services it provided.

Principle 4 - Services ✔ Standards met

Summary findings

Overall, pharmacy team members manage and provide the pharmacy's services safely. The pharmacy suitably sources its medicines. And it stores and manages its medicines appropriately. The pharmacy's services are accessible to people, including people using wheelchairs. It has processes in place to help people understand and manage the risks associated with some medicines. But team members do not always supply people receiving their medicines in compliance packs with information leaflets to help them take their medicines in the safest way.

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 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. Packs for the same person were banded together with their relevant prescriptions, to help complete further checks and resolve queries. Some other packs were found in totes elsewhere in the storage area. These were banded together for each person and had the accompanying prescriptions available, but the packs were not properly labelled. A dispenser explained these packs had been prepared up to six weeks in advance of them being due for supply to help the team manage their workload. They had received batches of repeat dispensing prescriptions to enable them to prepare the packs in advance. But they had chosen not to label them until nearer to the date of supply because in the past, they had received several queries from people questioning whether they had been provided with the most recent pack, when the pack had been labelled and prepared four to six weeks earlier. The dispenser also explained that they only prepared medicines in packs this far in advance once they had checked that medicines would be stable outside of their original containers during the storage period. And medicines that would not be stable were prepared closer to the date of supply. This was discussed with the superintendent pharmacist (SI) who agreed to immediately amend the standard operating procedure for pack preparation and dispensing to make sure that packs made in advance were always properly labelled, and the team would discuss an alternative way of managing people's expectations about the packs provided.

The pharmacist completed a clinical assessment of prescriptions for medicines provided in packs when a medicine was newly prescribed, when someone received packs from the pharmacy for the first time,

or if there were any changes to someone's medicines by their GP of following their discharge from hospital. And team members documented any changes to medicines provided in packs on the person's electronic patient medication record (PMR). A pharmacy technician routinely checked each pack for accuracy at the end of the preparation process. Team members who prepared packs, including the pharmacy technician, were clear about when they needed to refer prescriptions to the pharmacist for clinical assessment. If someone's medicines were stable and their prescriptions were not highlighted for any of the pre-defined reasons, then prescriptions would bypass a pharmacist's intervention. This meant there was a small risk of some people's prescriptions, whose treatments were stable, being dispensed for an undefined period without any further clinical assessment by a pharmacist. This was discussed with the SI who agreed to immediately implement a system to ensure that all prescriptions for medicines provided in packs would be clinically assessed by a pharmacist regularly.

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. They checked if the person was aware of the risks if they became pregnant while taking the medicine. And whether they were on a pregnancy prevention programme and using effective contraception. The pharmacy had stock of some information materials to give to people to help them manage the risks of taking valproate. The pharmacy delivered medicines to people, and it recorded the deliveries 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 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, and they recorded their checks. They highlighted short-dated medicines up to 12 months before their expiry by attaching a coloured sticker to the pack. They then relied on people noticing highlighted packs while dispensing to remove them before they expired. No out-of-date medicines were found on the shelves when these were randomly checked, and several packs were highlighted with stickers. The team discussed implementing a monthly stock expiry record to help prevent medicines expiring before they were noticed and 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 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.