General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: The Pharmacy Hub, 4 Batley Road, HECKMONDWIKE, West Yorkshire, WF16 9NE

Pharmacy reference: 1039573

Type of pharmacy: Community

Date of inspection: 14/11/2019

Pharmacy context

This is a community pharmacy in the town of Heckmondwike, 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. And it offers services including a home delivery service, a substance misuse service and medicine use reviews (MURs). It also supplies medicines in multi-compartmental compliance packs to people living in their own homes.

Overall inspection outcome

✔ **Standards met**

Required Action: None

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 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 identifies and manages the risks associated with the services it provides to people. And it provides team members with up-to-date written procedures for them to follow to help deliver services safely. The pharmacy keeps most of the records it must have by law. And it keeps people's private information secure. During periods of change, the pharmacy team members ask people for their views. This helps ensure they continue to provide a good service. The team members discuss and record any mistakes that they make when dispensing. So, they can learn from each other. And they implement changes to minimise the risk of similar mistakes happening in the future. The team members know when to raise a concern to help safeguard the welfare of vulnerable adults and children.

Inspector's evidence

The pharmacy had recently changed ownership, and at the time of the inspection, the pharmacy's owners were in the process of providing the pharmacy team with a new set of written standard operating procedures (SOPs). The SOPs were being sent to the responsible pharmacist (RP) periodically for her to review and to make any recommendations. The pharmacist had signed off 48 SOPs and was expecting to complete signing off the remaining SOPs within the next few weeks. The SOPs were due to be reviewed again every two years to make sure they were up-to-date. Following the inspection, the pharmacy's superintendent pharmacist confirmed to the inspector that all the SOPs had been approved and signed off. And each team member had read the SOPs that were relevant to their role. The pharmacy defined the roles of the team members in each SOP. They described how they would ask the pharmacist if there was a task they were unsure about or felt unable to deal with.

The pharmacy recorded near miss errors made while dispensing, onto a paper near miss log. The errors were typically spotted by pharmacist completing the final check. The team member who made the error was responsible for entering the details of the error. The team members explained this helped them take ownership and responsibility for their errors and helped with their learning. The details recorded included the time and date of the error, but not the reason why the error may have occurred. And so, the team may have missed out on some opportunities to learn from their mistakes and make specific changes. The pharmacy completed an analysis of the errors that had been recorded each month. This was to identify any trends or patterns. And the findings were discussed with the team when most of the team members were working. Those team members who were not working, were informed of the findings when they next attended for work. The pharmacist explained she had noticed a series of selection errors with medicines that looked or sounded similar, known as LASA medicines. The team members discussed the errors in a monthly meeting and considered the steps they could take to prevent similar errors happening again. For example, they discussed the importance of ensuring that dispensing labels attached on LASA medicines were double signed by the dispenser. This measure gave the pharmacist assurance that the medicine had been checked thoroughly before they completed their final check. The pharmacy had a similar system to record details of any dispensing errors which had reached the patient. The details of the error were recorded, including a record of why the error may have happened. The pharmacy kept the details of the error for future reference. The pharmacy had not had any errors to report since it had changed ownership.

The pharmacy collected verbal feedback from the people who used it. The team members explained they had been proactively asking people for feedback since the pharmacy changed ownership to ensure

people continued to receive a high quality of service. The pharmacy had improved it delivery service following feedback from people. It ensured it was able to provide people with next day, or sometimes even a same day delivery if there was an urgent request. The pharmacy did not advertise how people could raise a concern or make a complaint. The team members explained they had not had any formal complaints since the takeover of the pharmacy. And they would always attempt to resolve any complaints informally. If they were unable to do so, they would escalate the complaint to the pharmacy's owners.

The pharmacy had up-to-date professional indemnity insurance. The responsible pharmacist notice displayed the name and registration number of the responsible pharmacist on duty. The entries in the responsible pharmacist record often did not have the time the responsible pharmacist's duties had ended. This is not in line with 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 checked the running balances against physical stock at least every month. A physical balance check of fentanyl 50mcg patches and Medikinet 10mg tablets matched the balance in the register. The pharmacy kept complete records of CDs returned by people to the pharmacy.

The team members were aware of the need to keep people's personal information confidential. And they were seen offering the use of the consultation room to people to discuss their health in private. They had all undertaken general data protection regulation (GDPR) training. The team held records containing personal identifiable information in areas of the pharmacy that only the 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 third-party contractor.

The pharmacist had completed level two safeguarding training via the Centre for Pharmacy Postgraduate Education (CPPE). The other team members had completed some training in their previous roles with other pharmacies. A dispenser gave some examples of symptoms that would raise her concerns. And she described how she would raise any concerns with the pharmacist on duty. The pharmacy did not have any written guidance for the team to use to help them manage a concern. But the team members explained they would use the internet to find the contact numbers of the local safeguarding team and ask for advice.

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 to ensure people receive a high-quality service. The pharmacy team members complete some training to keep their knowledge and skills up to date. They feel comfortable making suggestions to improve the pharmacy's services. And can raise professional concerns when necessary.

Inspector's evidence

At the time of the inspection the regular pharmacist was supported by a full-time pharmacy assistant, who was training to be a pharmacy technician, and a locum pharmacy assistant. The pharmacist worked every day except on Wednesdays. The pharmacy used a regular locum pharmacist to work each Wednesday and cover any of the pharmacist's holidays. An additional part-time pharmacy assistant and two delivery drivers were not present during the inspection. The pharmacy organised the team rotas in advance to ensure enough support was available during the pharmacy's busiest times. It had recently started to increase the hours it allocated for locum dispensers. This was because the workload had recently increased for the team. The pharmacist and the full-time pharmacy assistant were relatively new to the pharmacy. They explained they had found their roles challenging, especially as the pharmacy had recently changed ownership, but enjoyable.

The pharmacy did not have a formal training programme in place for the team members to ensure their knowledge and skills were refreshed and up-to-date. The pharmacy assistant explained they took time out during the working day to read trade press materials. The pharmacy did not retain any records of completed training. The pharmacy was scheduled to provide each team member with a performance appraisal in the coming weeks. And the process was to be repeated each year. The appraisals were an opportunity for the team members to discuss which aspects of their role they enjoyed and where they would like to improve. The pharmacy assistant explained she was looking forward to her appraisal, but she was encouraged to discuss and concerns with the pharmacist as soon as she felt the need to do so. For example, the assistant had recently asked for help using the pharmacy's dispensing software as she had never used it before. The pharmacist got in touch with the software provider. The provider sent a trainer to the pharmacy who provided the team with a training session. And the team had the opportunity to ask any questions.

The team attended ad-hoc, informal meetings and discussed topics such as company news, targets and patient safety, when the pharmacy was quiet. If a team member was not present during the discussions, they were updated the next time they attended for work. The team members felt comfortable to give feedback or raise concerns with the regular pharmacist or the pharmacy's superintendent pharmacist. The team was set various targets to achieve. These included the number of prescription items they dispensed and the number of services they provided. The team members felt the targets did not impact their ability to make professional judgements.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is kept secure and is well maintained. The premises are suitable for the services the pharmacy provides. But the pharmacy doesn't have hot running water for its staff to use. It has a sound-proofed room where people can have private conversations with the pharmacy's team members.

Inspector's evidence

The pharmacy was clean and professional in appearance. The building was easily identifiable as a pharmacy from the outside. There was a first-floor area used to store various items such as medicine bottles and some dispensed multi-compartmental compliance packs. The dispensary was generally tidy and well organised during the inspections. Floor spaces were kept clear to minimise the risk of trips and falls. There was a fire exit which led to the rear of the building. The door was kept closed to prevent unauthorised access.

There was a clean, well-maintained sink in the dispensary for medicines preparation and staff use. There was a WC which had a sink. But the pharmacy did not have a hot water supply installed, as is required.

There was a good-sized, soundproofed consultation room at the side of the retail area. The room was smart and professional in appearance and was signposted by a sign on the door. It was kept closed when it was not in use to prevent the risk of any unauthorised access. It contained two seats, so people could sit down with the pharmacist to receive advice and services. The temperature was comfortable throughout the inspection. Lighting was bright throughout the premises.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides services to help people manage their health and wellbeing. The team members take steps to identify people taking high-risk medicines. And they provide these people with advice and regular support to help them take these medicines safely. The pharmacy provides medicines to some people in multi-compartmental compliance packs to help them take them correctly. And it manages the risks associated with the service appropriately. The pharmacy sources its medicines from licenced suppliers. And it stores and manages its medicines suitably.

Inspector's evidence

The pharmacy had stepped access from the street to the main entrance door. The pharmacy did not have a ramp or any other facilities to assist people with prams of wheelchairs to enter the premises unaided. The pharmacy could supply people with large print dispensing labels if needed. The pharmacy advertised its opening hours in the main window. The team members explained that many Asian people used the pharmacy and their first language was not always English. They helped them by communicating with them in Urdu or Punjabi. A dispenser was seen speaking to a person in Punjab and helping them to understand how to take their medicines correctly.

The team members regularly used various stickers that they could use as an alert before they handed out medicines to people. For example, to highlight if a person was eligible for a medicines use review. The team members signed the dispensing labels to indicate who had dispensed and checked the medication. And so, a robust audit trail was in place. Baskets were available to hold prescriptions and medicines. This helped the team stop people's prescriptions from getting mixed up. The team had a robust process to highlight the expiry date of CD prescriptions awaiting collection in the retrieval area. 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 team attempted to complete the owing the next day. The pharmacy kept records of the delivery of medicines from the pharmacy to people. The records included a signature of receipt. And so, there was an audit trail that could be used to solve any queries. The pharmacy asked people to sign the back of delivery sheets to prevent people seeing other people's personal details. A note was posted to people when a delivery could not be completed. The note advised them to contact the pharmacy.

The pharmacy supplied medicines in multi-compartmental compliance packs for people living in their own homes. And it supplied the packs to people on either a weekly or monthly basis. The team was responsible for ordering people's prescriptions. And this was done around a week in advance to give the team members the time to resolve any queries, such as missing items or changes in doses, and to dispense the medication. They dispensed the medication on a bench furthest away from the retail area. This was to minimise distractions. The pharmacy stored each person's documents, for example, the master sheets and prescriptions in individual baskets. The team members managed the workload over a four-week cycle to spread the work out evenly. And they completed the dispensing of the packs around a week before the pack was due to be supplied. The team members used the master sheets to check off prescriptions and confirm they were accurate. The sheets detailed each medicine the person was regularly prescribed. And the time they were to take it. The team also kept details of any changes to people's medicines. And it kept records of who had authorised the change, for example, the person's

GP. The packs were supplied with information which listed the medicines in the packs and the directions. And information to help people visually identify them. For example, the colour or shape of the tablet or capsule. The pharmacy routinely provided patient information leaflets with the packs.

The pharmacy dispensed high-risk medicines for people such as warfarin. The team members annotated prescriptions attached to people's medication bags to remind them that the bag contained a high-risk medicine. The pharmacist gave the person collecting the medicine additional advice if there was a need to do so. And checked they were having regular blood tests and looked at their anti-coagulant book if they had it with them. The pharmacy delivered many people's medicines. And so, the team would often not have face-to-face contact with people. The team members telephoned each person who they delivered warfarin to, each week to check if they understood the dose of warfarin they were to be taking. Andto check if they had been having regular blood tests. The pharmacist was seen reminding a person prescribed warfarin of the importance of having regular blood tests. 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. The team had access to literature about the programme that they could provide to people to help them take their medicines safely. The team had completed a check to see if any of its regular patients were prescribed valproate. And met the requirements of the programme. No-one had been identified.

Pharmacy (P) medicines were stored behind the pharmacy counter. So, the pharmacist could supervise sales appropriately. The pharmacy stored its medicines in the dispensary tidily. Every two months, the team members checked the expiry dates of its medicines to make sure none had expired. No out-of-date medicines were found after a random check. And the team members used alert stickers to help identify medicines that were expiring within the next three months. They recorded the date liquid medicines were opened on the pack. So, they could 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. And the team had access to CD destruction kits.

The team was not currently scanning products or undertaking manual checks of tamper evident seals on packs, as required under the Falsified Medicines Directive (FMD). The team had not received training on how to follow the directive and did not have the correct type of scanners installed. The team was unsure of when they were to start following the directive. Drug alerts were received via email to the pharmacy and actioned. But the pharmacy did not retain records of the alerts or the action taken. And so, a robust audit trail was not in place. The pharmacy checked and recorded the fridge temperature ranges every day. And a sample checked were within the correct ranges. The CD cabinets were secured and of an appropriate size. The medicines inside the fridge and the 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 uses its equipment 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-compartmental compliance packs. 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.

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.