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: 05/10/2022

Pharmacy context

The pharmacy is in a residential area of Heckmondwike. 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, including to people living in nursing homes. 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 to its services. And it has the documented procedures it needs relevant to its services. Pharmacy team members understand their role to help protect vulnerable people. And they suitably protect people's private information. Pharmacy team members sometimes record and discuss the mistakes they make to learn from them. But they don't record all their mistakes or identify why mistakes happen and so they may miss opportunities to make improvements to the pharmacy's services.

Inspector's evidence

The pharmacy had a set of standard operating procedures (SOPs) in place to help pharmacy team members manage the risks to its services. The superintendent pharmacist (SI) had reviewed the SOPs in 2022. And they had a plan to review them again in 2024. Most pharmacy team members had signed to confirm they had read and understood the procedures since the latest review. The responsible pharmacist (RP) was the pharmacy's new manager and had started working at the pharmacy at the beginning of September 2022. They had not read the SOPs. This was discussed. And the RP gave their assurance that they would read the procedures as soon as possible.

Pharmacy team members highlighted and recorded near miss and dispensing errors they made when dispensing. There were documented procedures to help them do this effectively. They sometimes discussed their errors and why they might have happened. And 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 ramipril tablets and capsules, to help prevent the wrong medicines being selected. But team members admitted they did not always discuss or record every mistake they made. This was reflected in the volume of near miss records available. The records that were available contained little or no information about why mistakes had been made. Or the changes team members had made to prevent them happening again. The pharmacy did not analyse the data collected for patterns. This meant team members might miss out on opportunities to learn and make improvements to the pharmacy's services. The pharmacy recorded dispensing errors, which were errors identified after the person had received their medicines. But during the inspection, pharmacy team members could not find the records they had made of their errors. So, the quality of their recording could not be assessed. This was discussed. Team members clearly explained how they managed dispensing errors and how they would make sure people were safe. They explained their previous manager recorded dispensing errors. And they were unsure where they had filed their previous records.

The pharmacy had a documented procedure to deal with complaints handling and reporting. It collected feedback from people verbally. The pharmacy did not have any records of any feedback received. Team members gave an example of adjusting the way they communicate key information with their delivery drivers. This was after the pharmacy had received feedback from some people about drivers not allowing enough time to get to the door when they delivered. Team members now added notes of key information to the label on each bag to alert the driver if someone needed extra time. Or, for example if someone had requested a phone call to alert them their delivery was on the way and help them to prepare. Team members explained people had been grateful of these changes. And they meant the pharmacy had to manage fewer failed deliveries.

The pharmacy had up-to-date professional indemnity insurance in place. It maintained a responsible pharmacist record electronically, which had frequent gaps in the sign-out times of the RP. The pharmacy kept controlled drug (CD) registers complete and in order. It kept running balances in all registers. These were audited against the physical stock quantity monthly, including methadone. The inspector checked the running balances against the physical stock for three products. And these were correct. The pharmacy kept private prescription and emergency supply records. And these records were complete.

The pharmacy kept sensitive information and materials in restricted areas. It collected confidential waste in dedicated bags. A contractor collected these bags each month and took them for secure destruction off-site. 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. Examples included using the pharmacy's consultation room to have private discussions with people. And moving away from the pharmacy counter to have a sensitive telephone conversation with someone. A pharmacy team member gave some 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 a list of local safeguarding contacts was displayed for team members to use. Pharmacy team members had completed training about safeguarding in 2019. And the RP confirmed the training was due to be updated in 2022.

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 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 pharmacist manager, a pharmacy technician, a trainee pharmacist, and three dispensers. And they were managing the workload. 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. They had recently completed modules about weight management and risk management as part of the requirements of the Pharmacy Quality Scheme. Pharmacy team members received an appraisal each year with the manager. They discussed their performance, and any learning needs they had. And discussed any concerns. Team members explained they did not usually set formal objectives to work towards. But their previous manager signposted them to training and appropriate resources to help them address any learning needs they had identified.

Pharmacy team members felt comfortable sharing ideas to improve the pharmacy's services. Following a discussion, the pharmacy had changed its dispensing baskets, so they were colour coded. This helped the team to prioritise their workload by placing prescriptions with different priorities into different coloured baskets. Team members explained their changes had worked well. And they now felt more organised and able to complete the right prescriptions at the right time. Pharmacy team members explained they would raise professional concerns with the pharmacy manager or the pharmacy's owners. 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 available and pharmacy team members knew how to access the process.

Principle 3 - Premises ✔ Standards met

Summary findings

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

Inspector's evidence

The pharmacy was clean and well maintained. It was tidy and well organised. The pharmacy's floors and passageways were free from clutter and obstruction. It kept equipment and stock on shelves throughout the premises. The pharmacy prepared and stored multi-compartment compliance packs on the first floor. 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 maintained heat and light to acceptable levels. Its overall appearance 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 access to the restricted areas of the pharmacy.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's services are generally accessible to people. The pharmacy has systems in place to help provide its services safely and effectively. It sources its medicines appropriately. And it stores and manages its medicines properly. Pharmacy team members work together to resolve queries about people's prescriptions. And they sometimes provide people with information to help them take their medicines safely.

Inspector's evidence

The pharmacy had stepped access from the street. People knocked on the door to attract attention if they needed help. 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 with to help communicate with people with hearing impairment.

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. These baskets were colour coded according to the priority of each prescription to help them organise their workload. For example, red baskets indicated someone was waiting in the pharmacy, and green and grey baskets each indicated prescriptions to be delivered on different delivery routes taken by the pharmacy's drivers. Pharmacy team members had implemented a communications diary in the pharmacy. They used the diary to record conversations they had with people about their medicines and prescriptions. And to record any queries they had raised about prescriptions with local surgeries. The explained the diary helped them keep track of their work, particularly when they raised queries about prescriptions. It also enabled other team members working on different shifts to be fully aware of progress and to be able to continue resolving queries later. 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 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. This was discussed, and team members gave their assurances that they would routinely provide information leaflets to people immediately. 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 on their electronic patient medication record (PMR). The pharmacy also provided medicines in packs to people living in a nursing home in the local community. The team at the home ordered their own prescriptions directly with GP surgeries. They sent a copy of their order to the pharmacy. Pharmacy team members reconciled the prescriptions they received against the orders. And informed the care home's staff if there were any queries or discrepancies. The pharmacy delivered medicines to people. 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 stored medicines on shelves. 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 fridges where medicines were stored each day. And they recorded their findings. The temperature records seen were within acceptable limits. Pharmacy team members checked medicine expiry dates every three months. And up-to-date records were seen. They highlighted and recorded any short-dated items up to six months before their expiry. And they removed expiring items at the beginning of their month of expiry.

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 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 a suitable container available to segregate its confidential waste ready for collection. It kept its computer terminals in the secure areas of the pharmacy, away from public view. And these were password protected. The pharmacy restricted access to all equipment.

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.