General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Medicare Chemists Ltd., 5 Copthorne Square, Bradley, HUDDERSFIELD, West Yorkshire, HD2 1SZ

Pharmacy reference: 1039591

Type of pharmacy: Community

Date of inspection: 08/08/2019

Pharmacy context

This is a community pharmacy in the village of Bradley, Huddersfield. The pharmacy sells over-the-counter medicines and dispenses NHS prescriptions. It also dispenses private prescriptions. The pharmacy team offers advice to people about minor illnesses and long-term conditions. And it offers services including medicines use reviews (MURs), a collection and delivery service, a substance misuse service and the NHS New Medicines Service (NMS). It also supplies medicines in multi-compartmental compliance packs to people living in their own 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	2.2	Good practice	The pharmacy is good at supporting its team members to ensure their knowledge and skills are up to date. It achieves this by providing them with a structured training programme and regular appraisals of their performance. The team members can tailor their training to help them achieve personal goals.
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 has suitable processes and written procedures to protect the safety and wellbeing of people who access its services. It keeps the records it must have by law. And it keeps people's private information secure. The pharmacy team members have adequate tools available to them to safeguard the welfare of vulnerable adults and children. The pharmacy team members discuss and learn from any errors they make while dispensing. And they take steps to make sure the errors are not repeated.

Inspector's evidence

The pharmacy was relatively small with limited bench space in the dispensary. It had a small open plan retail area which led straight to the pharmacy counter. The pharmacy counter provided a barrier between the retail area and the dispensary. The pharmacist used a rear bench close to the pharmacy counter to do final checks on prescriptions, which helped him oversee sales of over-the-counter medicines and conversations between team members and people at the counter.

The pharmacy had a set of standard operating procedures (SOPs). And these were held in a ring binder. There was an index. And so, it was easy to find a specific SOP. The SOPs covered various processes including taking in prescriptions and dispensing. The team members were seen working in accordance with the SOPs. The SOPs were prepared by the pharmacy's owners in 2013 and were scheduled to be reviewed every two years. The last recorded review was in 2018. The pharmacy defined the roles of the pharmacy team members in a matrix at the rear of the ring binder. The matrix showed who was responsible for performing each task. A pharmacy assistant said she would ask the pharmacist if there was a task they were unsure about. Or felt unable to deal with. It was not clear if all the team members had read and signed the SOPs that were relevant to their role.

The pharmacy had a process to report and record near miss errors that were spotted during dispensing. The pharmacist typically spotted the error and then informed the dispenser that they had made an error. The dispenser made a record of the error onto a near miss log. The records contained details such as the date of the error and the team members involved. But the team members did not record why the error may have happened. And so, they may have missed out on the opportunity to learn from the mistake and make appropriate improvements. The team members discussed the error when it happened and tried to include all the team members present into the discussion. The near misses were analysed for any trends and patterns and the findings were documented and kept for future reference. The analysis was rotated between two dispensers. The team had recently identified quantity errors as being the most common type. The team discussed actions for improvement and collectively decided they should ensure 'split' boxes were properly identifiable by marking the packaging on each panel with a pen. The team had also discussed medicines that looked alike or sounded alike (LASA). The dispenser demonstrated warning notes that had been placed in front of several LASA medicines. This was to highlight the risk of incorrectly selecting these medicines and to help prevent errors. The pharmacy had a process to record dispensing errors that had been given out to people. It recorded these incidents and a copy of the report was sent to the company head office for analysis and kept in the pharmacy for future reference. The reports included the details of who was involved, what happened, why it happened, and what actions the pharmacy intended to implement to prevent a similar error happening again. An example of a recent incident involved the pharmacy mixing up two medicines that sounded similar. The team ensured that the two medicines were separated on the dispensary shelves to reduce

the risk of them being picked in error.

The pharmacy advertised how the people who used the pharmacy could make comments, suggestions and complaints, via a notice in the retail area. The pharmacy collected feedback from people through an annual survey. But the results of the latest annual survey were not available for inspection. The pharmacy was visited twice a year by a mystery shopper. The pharmacy was assessed by the shopper on the cleanliness of the premises, the ease of being able to find products for sale, and the advice they were given by a team member when they asked to purchase an over-the-counter medicine. The team achieved a 90 percent score on the latest visit.

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. Entries in the responsible pharmacist record complied with legal requirements. The pharmacy kept complete records of private prescription and emergency supplies. The pharmacy kept the certificates of conformity of special supplies. And a sample seen was completed correctly as required by the Medicines and Healthcare products Regulatory Agency (MHRA). The pharmacy kept controlled drugs (CDs) registers. They were in order including completed headers, and entries made in chronological order. The pharmacy team checked the running balances against physical stock each month. The pharmacy kept complete records of CDs returned by people to the pharmacy.

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 destroyed periodically. The pharmacy did not outline to people using the pharmacy how it stored and protected their information. The team members understood the importance of keeping people's information secure. The pharmacy had recently submitted its information governance framework toolkit.

The pharmacist on duty had completed training on the safeguarding of vulnerable adults and children up to level 2 via the Centre for Pharmacy Postgraduate Education. The team members gave several examples of symptoms that would raise their concerns. And the dispenser said she would discuss their concerns with the pharmacist on duty, at the earliest opportunity. A guide to managing and reporting a potential concern was kept in the dispensary. And so, the team could easily access it. A list of the key local safeguarding teams was available to the team.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough team members to manage the services it provides. The pharmacy is good at supporting its team members to ensure their knowledge and skills are up to date. It achieves this by providing them with a structured training programme and regular appraisals of their performance. The team members can tailor their training to help them achieve personal goals. The team members openly discuss how to improve ways of working. And they regularly talk together about why mistakes happen, and how they can make improvements. And they feel comfortable to raise professional concerns when necessary.

Inspector's evidence

At the time of the inspection, the team members present were the regular full-time pharmacist and a part-time trainee pharmacy assistant who also worked as the pharmacy's delivery driver. The pharmacy also employed two full-time pharmacy assistants. The team members did not take time off in the few weeks before Christmas. As this was the pharmacy's busiest period. The pharmacy could call on the help of team members from other local Medicare branches to cover planned and unplanned absences. The pharmacist on duty supervised the dispenser. And she was seen involving the pharmacist in offering advice to people who were purchasing over-the-counter products for various minor ailments. The pharmacist and dispenser carried out their tasks and managed their workload in a competent manner. The dispenser asked appropriate questions when selling medicines that could only be sold under the supervision of a pharmacist. And she was clear about the activities she could and could not do in the absence of a responsible pharmacist.

The pharmacy enrolled each team member onto an online learning system called virtual outcomes. The system contained various modules on healthcare related topics. The team members were required to complete a mandatory each month and could choose a module voluntarily at any time. Each team member had a file in which they kept records of all completed training. They received designated time to complete training during the working day. Which allowed the team to complete the training without any distractions. The team had recently completed GDPR training. The trainee pharmacy assistant said she received a lot of support from her colleagues and felt comfortable asking questions. The pharmacy had a structured appraisal process designed to support its team members. The appraisals were an opportunity for the team members to discuss what parts of their roles they felt they enjoyed and which parts they felt they wanted to improve. And discuss their personal development. The team members were then set objectives to help them achieve their goals.

The team did not have regular, formal meetings. But as it was a small team, the team members 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 openly and honestly discussed any mistakes they had made while dispensing and discussed how they could prevent the mistakes from happening again. And the team members felt comfortable to give feedback to the pharmacy’s owners, to help improve the pharmacy’s services. The team explained they had recently discussed making the pharmacy retail area smaller to allow for a bigger dispensary. This proposal was currently under review.

The team members said they were able to discuss any professional concerns with the pharmacist or with the company head office personnel. They were aware the company had a whistleblowing policy.

And so, the team could raise a concern anonymously. The pharmacy asked the team to achieve targets. Targets included the number of patients who nominated the pharmacy to receive their electronic prescriptions, the number of medicine use review and new medicines service consultations completed. The pharmacy also had a target for the number of prescription items dispensed. The team members did not feel under any pressure to achieve the targets, but they always strived to do so.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is secure and suitably maintained. It has a sound-proofed room where people can have private conversations with the pharmacy's team members.

Inspector's evidence

The pharmacy was generally clean and well maintained. But it appeared dated, particularly externally. The benches were cluttered with baskets and paperwork, but this improved as the inspection progressed. Floor spaces were clear with no trip hazards evident. There was a clean, well-maintained sink in the dispensary for medicines preparation and staff use. There was an outdoor WC available for staff use. It was adequately maintained. The pharmacy had a sound-proofed consultation room which contained adequate seating facilities. The room was smart and professional in appearance. 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 provides an appropriate range of services to help people meet their health needs. The team members help people to safely take their high-risk medicines and they give them additional advice when it is necessary. They manage the risks associated with dispensing medicines in multi-compartmental compliance packs with suitable processes. The pharmacy has some good systems to make sure the team members source, store and manage medicines safely. But when the pharmacy delivers medicines to people at home it doesn't ask people to sign for their delivery. So, it may be difficult to resolve any queries.

Inspector's evidence

The pharmacy was accessible via a step from the street, to a push/pull door. There was no ramp available. And so, people using wheelchairs may not have been able to enter the premises. But a doorbell was affixed next to the entrance door. And people could use it to attract the attention of a team member if they needed any assistance. Large print labels were provided on request. The team members had access to the internet. Which they used to signpost people requiring a service that the team did not offer. The pharmacy advertised its services and opening hours in the retail area. A poster advertising a travel vaccination service was affixed to the main window. The service was undertaken at another local Medicare branch and people who asked about the service were signposted accordingly. Seating was provided for people waiting for prescriptions.

The team members regularly used various stickers during dispensing 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 to indicate who had dispensed and checked the medication. And so, a robust audit trail was in place. The dispensary had a manageable workflow with separate areas for the team members to undertake the dispensing and checking parts of the dispensing process. They used baskets to hold prescriptions and medicines. This helped the team members stop people’s prescriptions from getting mixed up. The team used marker pens to highlight date of issue of CDs that did not require safe custody. This system prevented the team members 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 team attempted to complete the owing the next day. The pharmacy offered a service to deliver medicines to people’s homes. But it did not ask people to sign that they had successfully received their medicines. And so, an audit trail that could be used to solve any queries, was not available. A note was posted to people when a delivery could not be completed. The note advised them to contact the pharmacy.

The team members were aware of the risks associated with the supply of high-risk medicines. And they used alert stickers for warfarin, lithium and methotrexate to attach to bags which contained these medicines. The alert stickers were used to remind the team members to show the bag to the pharmacist before it was handed to the person. The pharmacist often gave the person additional advice if there was a need to do so. But details of these conversations were not recorded on people’s medication records. So, the pharmacy could not demonstrate how often these checks took place. The

team members were aware about the requirements of the valproate pregnancy prevention programme. The team members had access to a support pack which contained warning stickers and leaflets which could be given to people. The team had not completed a check to see if any of its regular patients were prescribed valproate and met the requirements of the programme.

The pharmacy supplied medicines in multi-compartmental compliance packs for people living in their own homes. And the pharmacy supplied the packs to people on either a weekly or monthly basis. The team members were responsible for ordering the person's prescription. And they did this around a week in advance. And then they cross-referenced the prescription with a master sheet to ensure it was accurate. The team members queried any discrepancies with the person's prescriber. The team members recorded details of any changes, such as dosage increases and decreases, on the master sheets. They dispensed the packs on a side bench which was out of the line of sight of the retail area. This was to make sure they weren't distracted while dispensing. But the bench was small, and the team said they could often feel cramped in the space. The packs had dispensing labels attached. And the labels contained information to help people visually identify the medicines. The team routinely provided patient information leaflets with the packs.

Pharmacy only medicines were stored behind the pharmacy counter. The storage arrangement prevented people from self-selecting these medicines. The pharmacy had a date checking schedule to be completed every three months and it used stickers to highlight short-dated stock. It kept a record of the process. Some short-dated stickers were seen on the dispensary shelves. The team members recorded a list of medicines that were expiring over the next twelve months. They checked the records at the beginning of the relevant month and removed the medicines that were still stocked. The team members recorded the date liquid medicines were opened on the pack. So, they could check they were in date and safe to supply. The team members were scanning products and undertaking manual checks of tamper evident seals on packs, as required under the Falsified Medicines Directive (FMD). Each team member had received training on how the follow the directive. A guide was available to the team to help them manage any issues with the FMD software. The team members scanned barcodes on bag labels to maintain an audit trail of when medicines were handed out to people.

Fridge temperatures were recorded daily using digital thermometers. A sample of the records were looked at. And the temperatures were found to be within the correct range. The thermometer was reset each day to ensure it gave an accurate reading. The pharmacy obtained medicines from several reputable sources. Drug alerts were received via email to the pharmacy and actioned. The pharmacy kept a record of which team member had actioned the alert and what the action was. And so, a robust audit trail was in place that could be used in the event of a query.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy's equipment is clean and safe to use. And the pharmacy generally protects people's confidentiality.

Inspector's evidence

References sources were in place. And the team had access to the internet as an additional resource. The resources included hard copies of the British National Formulary (BNF) and the BNF for Children. The pharmacy used a range of CE quality marked measuring cylinders. Separate cylinders were used to dispense methadone. A separate tablet counter was used to dispense methotrexate and other cytotoxic medicines. The fridge used to store medicines was of an appropriate size. And the medicines inside were organised in an orderly manner. There was no evidence of electrical equipment having been subjected to portable appliance testing. But the equipment appeared to be in good working order and well maintained.

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 on view to the public. The computers were password protected. Cordless phones assisted the team in undertaking confidential conversations.

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.