General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Well, 38 Commercial Road, Skelmanthorpe, HUDDERSFIELD, West Yorkshire, HD8 9DA

Pharmacy reference: 1039592

Type of pharmacy: Community

Date of inspection: 22/06/2023

Pharmacy context

The pharmacy is on a high street in Skelmanthorpe. It dispenses NHS prescriptions and sells a range of over-the-counter medicines. Pharmacy team members provide services to people, including the NHS Hypertension Case Finding Service, Covid-19 booster vaccinations and seasonal flu vaccinations. They provide medicines to people in multi-compartment compliance packs, and the pharmacy delivers medicines to people's 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 risks associated with its services well. And it has documented procedures to help it 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.

Inspector's evidence

The pharmacy had a set of standard operating procedures (SOPs) to help pharmacy team members manage the risks to its services. These were available electronically, and team members knew how to access them. The superintendent pharmacist's (SI) office reviewed the procedures every two years on a monthly rolling cycle. It sent new and updated procedures to pharmacy team members via its eExpert training system. Pharmacy team members read the procedures, and they completed a test after reading each one. If they passed the test, they could complete the sign off process on their learning record. The pharmacy received a bulletin approximately every month from the company's professional standards team, called "Share and Learn", which communicated professional issues and learning from across the organisation following analysis of near miss and errors. The bulletin also provided best practice guidance on various topics and case studies based on real incidents that had occurred. It detailed how pharmacy team members could learn from these. Pharmacy team members read the bulletin and signed it to record that they had done so.

The pharmacy provided a Covid-19 booster vaccination service. The service remained popular, and the team vaccinated approximately 200 people per month. Pharmacy team members had completed a risk checklist provided by head office in 2022. The checklist considered various risks associated with providing a vaccination service to people, for example whether all team members had completed the necessary training, whether the correct documents were in place to support the service and whether the premises were suitable to provide vaccination services. Team members discussed the risks they identified and took steps to mitigate these, but this was not documented. One example was havening a suitable, dedicated space to prepare vaccinations. So, they had identified an area where this could happen safely, which was also close to the sink to help team members maintain proper hygiene. The responsible pharmacist (RP) explained they were currently experiencing difficulties obtaining stock of vaccinations. This meant they had cancelled several appointments in the last four weeks and signpost people to alternative places that could help. The RP had raised the issue with the company's vaccination lead, but the issue had not yet resolved.

The pharmacy had an electronic risk register available to use. The register included various risk assessments that had been completed about the pharmacy's services. Some of these had been populated by head office to help manage the risks of services provided across the organisation. But the team were also able to create their own risk assessment documents, which were shared with the SI office. Team members showed a risk assessment they had completed after a dispensing incident with a controlled drug (CD). They had discussed the risks identified with the error and made changes to help prevent the mistake happening again. Changes included reorganising how CDs were stored and installing another CD cabinet to provide more secure storage space, especially for completed multi-compartment compliance packs containing CDs.

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 discussed their 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. One example was changing the way they managed distractions from the telephone or people at the pharmacy counter while they were dispensing, to help prevent them making mistakes. Pharmacy team members did not always capture much information about why the mistakes had been made or the changes to prevent a recurrence to help aid future learning. But they gave their assurance that these details were always discussed. The pharmacy manager analysed the data collected every month to look for patterns. They recorded their analysis. And pharmacy team members discussed the patterns found at a monthly patient safety briefing. The pharmacy had a system in place to manage and record dispensing errors, which were errors identified after the person had received their medicines. Team members discussed dispensing errors at the time they were identified and as part of their monthly patient safety briefing. And they completed a root cause analysis of each error to help determine causes and the changes they could make to help improve safety.

The pharmacy had a documented procedure in place for handling complaints or feedback from people. Pharmacy team members explained feedback was usually collected via questionnaires and verbally from people. Any complaints were immediately referred to the pharmacist to handle. The pharmacy had a practice leaflet available, which included information for people about how to provide the pharmacy with feedback.

The pharmacy had up-to-date professional indemnity insurance in place. It kept accurate electronic CD registers, with running balances in all registers. Pharmacy team members audited the balances against the physical stock quantity every week. The pharmacy kept and maintained an accurate register of CDs returned by people for destruction. It maintained an RP record, which was complete and up to date. The pharmacist displayed their RP notice. Pharmacy team members kept accurate private prescription and emergency supply records.

The pharmacy kept sensitive information and materials in restricted areas. It collected confidential waste in dedicated bins, which were periodically emptied by a waste disposal contractor for secure destruction. The pharmacy had a documented procedure in place to help pharmacy team members manage sensitive information. Pharmacy team members completed mandatory assessments to confirm they had understood the procedure. And they completed mandatory confidentiality and information security training each year. Team members explained how important it was to protect people's privacy and how they would protect confidentiality.

The pharmacy had procedures for dealing with concerns about children and vulnerable adults. Pharmacy team members completed mandatory safeguarding training every two years. And team members were trained to different levels according to their qualifications and responsibilities. A pharmacy team member gave some examples of signs that would raise their concerns about vulnerable children and adults. And how they would refer their concerns to the pharmacist.

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 appropriate training to keep their knowledge up to date. They effectively discuss and implement changes to improve their services and make the pharmacy safer. Team members feel comfortable raising concerns with the right people if necessary. And they feel well supported by their colleagues and manager.

Inspector's evidence

During the inspection, the pharmacy team members present were the responsible pharmacist (RP) pharmacy manager and two qualified dispensers. Pharmacy team members completed mandatory e-learning modules issued by head office, which included any new or updated standard operating procedures. Some recent examples included training about hay fever and allergy and data protection. Pharmacy team members also regularly discussed learning topics informally and the pharmacist highlighted topics for team members to learn more about. They completed mandatory training during working hours. Pharmacy team members received an appraisal with the pharmacy manager each year to discuss and reflect on their own performance and identify any learning needs.

Pharmacy team members explained they would usually raise professional concerns with their pharmacist or regional operations manager. They felt comfortable raising concerns and making suggestions to help improve the pharmacy's ways of working. They were confident that their concerns and suggestions would be considered, and changes would be made where they were needed. One recent example was the team discussing and reorganising the workload on the pharmacy manager’s day off each week to help minimise the impact on the workload the following day.

Pharmacy team members communicated openly during the inspection. The company asked them to achieved targets in various areas of the business, for example the number of prescription items dispensed, and the number of services being delivered. Team members explained they felt comfortable achieving the targets set. They explained their strategies for achieving their targets safely. And explained they were comfortable to have conversations with their regional operations manager if they did not achieve their targets.

Principle 3 - Premises ✔ Standards met

Summary findings

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

Inspector's evidence

The pharmacy was clean and well maintained. And the benches where medicines were prepared were tidy and well organised. The pharmacy's floors and passageways were free from clutter and obstruction. The pharmacy kept equipment and stock on shelves throughout the premises. It had a room on the first floor that team members used to prepare and store medicines in multi-compartment compliance packs. Team members kept the room clean, tidy, and well organised.

The pharmacy had a private consultation room, which was clearly signposted, and pharmacy team members used the room to provide services from and 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 which provided hot and cold running water and other facilities for hand washing. The pharmacy kept its heating and lighting to acceptable levels. Its overall appearance was professional and suitable for the services it provided.

Principle 4 - Services ✔ Standards met

Summary findings

Pharmacy team members manage the pharmacy’s services well to make sure that people receive the care they need. And they effectively use technology to help them do this. The pharmacy’s services are accessible to people, including people using wheelchairs. It sources, manages and stores its medicines properly. And it has processes in place to help people manage the risks of taking high-risk medicines.

Inspector's evidence

The pharmacy had level access from the street through automatic doors. Pharmacy team members explained how they would communicate in writing with people with a hearing impairment. And provide large-print labels and instruction sheets to help people with a visual impairment.

The pharmacy had a good proportion of its prescriptions dispensed at the company's off-site dispensing hub, where medicines were picked and assembled by a dispensing robot. Pharmacy team members explained that prescriptions were assessed to establish whether they were suitable to be sent to the hub. They continued to dispense prescriptions for urgent acute items, such as antibiotics, for medicines stored in the fridge and for prescriptions for unusual quantities of medicines. They used the hub most commonly for people's regular repeat medication. Pharmacy team members annotated on the electronic prescription token which items were being sent to the hub and which items were for the team to dispense. The pharmacist logged on to the system and performed a clinical and accuracy check of each prescription. Once the pharmacist was satisfied, they released the prescription which was then sent to the hub for assembly. The pharmacy received the medicines in sealed packages from the hub. Pharmacy team members married up the bags with the relevant prescriptions and any medicines that had already been prepared in the pharmacy. And the bags were added to the prescription retrieval shelves ready for collection or delivery.

Pharmacy team members attached labels to bags of dispensed medicines that contained a unique barcode. When they were ready to store a completed prescription bag on the retrieval shelves, they scanned the barcode using a hand-held device. The information on the device was linked to the electronic patient medication records system. Pharmacy team members chose a location to store the bag. And they scanned the barcode attached to the location and placed the bag on the shelf. When people came to collect their medicines, pharmacy team members entered their details into the hand-held device. The device then told them where the bags were stored. Pharmacy team members marked the bag as collected and a record was made of the time and date of collection. They explained that the system helped to prevent bags kept in different locations being missed and people leaving without all their prescription medicines. For example, if part of their prescription was being stored in the fridge or the controlled drugs cabinet as well as on a shelf. Pharmacy team members also explained that the system helped them to identify if a patient had forgotten to collect a prescription previously.

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. The pharmacy team 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. Pharmacy team members had completed an audit of people who received valproate from the pharmacy in January 2023. And this had helped to ensure that the right people had received the appropriate information and counselling.

The pharmacy supplied medicines to a significant number of people in multi-compartment compliance packs when requested, to help them take their medicines safely. It attached labels to the packs, so people had written instructions of how to take their medicines. Team members included descriptions on the packs of what the medicines looked like, so they could be identified in the pack. And they provided people with patient information leaflets about their medicines each month. Pharmacy team members documented any changes to medicines provided in packs using an event diary that was attached to the person's master record sheet, which was a record of all their medicines and the times of administration. They also recorded this on their electronic patient medication record (PMR). Team members kept records of communications they had with the GP surgeries and others about people's medicines, to help resolve future queries quickly. And they had designed a tracker system which they used to monitor the progress of each person's pack at each stage of the preparation process. Each completed pack was stored with the relevant prescription and was clearly marked with the date it was due to be supplied. The pharmacy delivered medicines to people via a delivery driver, who also delivered medicines for other local stores. The pharmacy used an electronic system to manage and record deliveries and it uploaded information to the driver's handheld device. Pharmacy team members highlighted bags containing controlled drugs (CDs) on the driver's device and on the prescription bag. The delivery driver left a card through the letterbox if someone was not at home when they delivered, asking them to contact the pharmacy. And they returned the medicines to 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 three pharmacy fridges each day and recorded their findings. The temperature records seen were within acceptable limits. Team members recorded weekly checks of medicine expiry dates. They completed checks in various areas of the pharmacy on a rolling cycle. This meant they checked all medicines every three months. Pharmacy team members highlighted and recorded any short-dated items up to twelve months before their expiry and recorded these items on an electronic system using a handheld device. The system prompted team members to remove expiring items at the beginning of their month of expiry. Pharmacy team members responded to any alerts or recalls they received about medicines from manufacturers and other agencies. These were sent to the pharmacy each day via the company's online task tracker. Team members removed any affected medicines from the shelves, and they recorded the actions they had taken.

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 suitable containers available to collect and segregate its confidential waste. It kept its password-protected computer terminals and bags of medicines waiting to be collected in the secure areas of the pharmacy, away from public view and where people's private information was protected.

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.