General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Medicare Chemists, Elmwood Health Centre, Huddersfield Road, Holmfirth, HUDDERSFIELD, West Yorkshire, HD9 3TR

Pharmacy reference: 1039601

Type of pharmacy: Community

Date of inspection: 28/08/2024

Pharmacy context

The pharmacy is adjacent to a GP surgery near Holmfirth. Pharmacy team members dispense NHS prescriptions and sell a range of over-the-counter medicines. The pharmacy provides services, such as the NHS Pharmacy First service. And team members deliver 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 adequately identifies and manages risks. It has the written procedures it needs relevant to most of its services to help team members provide services safely. Pharmacy team members understand their role to help protect vulnerable people. And they suitably protect people's confidential information. Team members record and discuss the mistakes they make so that they can learn from them. But they don't always follow documented procedures to help capture key information or analyse these records, so they may miss some opportunities to learn and improve.

Inspector's evidence

The pharmacy had a set of standard operating procedures (SOPs) in place to help pharmacy team members manage the risks with most of the pharmacy's services. But it did not have SOPs for some services or processes, such as the NHS Pharmacy First service and for dealing with a safeguarding concern. This meant team members may not always fully understand their responsibilities. The SOPs had been read by team members in 2024, and they had signed to confirm their understanding. The SOPs were also colour-coded according to job role, to help team members understand which parts of a process were their responsibility.

The pharmacy had recently started to provide the NHS Pharmacy First service to people. Pharmacy team members explained how the pharmacy had considered some of the risks of providing the service, such as the suitability of the pharmacy's consultation room to deliver the service from. And ensuring they had stock of the relevant medicines and the availability of the necessary equipment. They also ensured they had completed the necessary training. But the responsible pharmacist (RP) confirmed that these assessments had not been written down to help them manage emerging risks on an ongoing basis as the service developed. Pharmacy team members had created a poster which they displayed behind the pharmacy's retail counter. The poster highlighted the key inclusion criteria for each condition covered by the service. Team members used the poster as an aide memoire to help them appropriately refer people to the pharmacist for a consultation.

The pharmacist highlighted and recorded mistakes identified before people received their medicines, known as near misses. There were documented procedures to help them do this effectively. They used an electronic system to record the information. The pharmacist discussed mistakes with the team member involved. But they rarely discussed or recorded specific information about why the mistakes had been made. Or the changes they had made to prevent a recurrence and to help aid future reflection and learning. And they did not regularly analyse the data to establish patterns of mistakes. So, they may miss opportunities to learn and make improvements. The pharmacy recorded dispensing errors, which were errors identified after the person had received their medicines. The records available gave a clear explanation of the error. But these records also did not always document information about causes from all team members involved, to help make the most effective adjustments to improve safety.

The pharmacy had a documented procedure for handling complaints and feedback from people. But the process was not advertised to people in the pharmacy's retail area. Team members explained people usually provided feedback by leaving reviews online. The pharmacy had recently updated the information provided on an information screen in the pharmacy's retail area. This followed feedback that it was displaying out-of-date information.

The pharmacy had current professional indemnity insurance in place. It kept accurate CD registers and maintained running balances for all registers. But team members did not frequently audit the running balances, so any stock irregularities may be overlooked. The pharmacy kept a register of CDs returned by people for destruction. It maintained a responsible pharmacist record, and it was complete and up to date. The pharmacist displayed their responsible pharmacist notice. The pharmacy kept complete private prescription and emergency supply records.

The pharmacy kept sensitive information and materials in restricted areas. It collected confidential waste in dedicated bags. The bags were sealed when full and collected approximately monthly 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 explained how important it was to protect people's privacy and how they would protect confidentiality.

Pharmacy team members explained how they would raise their concerns about vulnerable children and adults. And how they would discuss their concerns with the pharmacist and other colleagues. Team members were also aware of how to find information about key local safeguarding contacts by using the internet. The pharmacy did not have a documented procedure for dealing with concerns about children and vulnerable adults. So, team members might not always be clear how to properly handle a concern. Team members completed formal safeguarding training every two years. And their next training update was due in 2024.

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 ongoing ad hoc learning to help keep their knowledge and skills up to date. And they feel comfortable raising concerns and discussing ways to improve services.

Inspector's evidence

At the time of the inspection, the pharmacy team members present were the responsible pharmacist (RP), a trainee pharmacist, three qualified dispensers, and a trainee dispenser. 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. The pharmacy did not have a formal appraisal or performance review process for pharmacy team members. A team member explained they used to have an appraisal with their previous manager, but they had not had one for some time since the manager had left. They explained how they would raise any learning needs verbally with the pharmacist or other colleagues. And they were supported by being signposted to relevant reference sources or by discussion to help address their learning needs. The trainee pharmacist had regular contact with their training supervisor each week. This provided them with regular opportunities to ask questions and raise learning needs. They explained how their supervisor continually challenged their knowledge to identify learning opportunities. And they were provided with an hour of protected learning time each day.

Pharmacy team members explained how they would raise professional concerns with the pharmacist, head office colleagues or the superintendent pharmacist (SI). They felt comfortable sharing ideas to improve the pharmacy or raising a concern. And they were confident that their concerns would be considered, and changes would be made where they were needed. The pharmacy did not have a formal whistleblowing policy. Pharmacy team members were aware of organisations outside the pharmacy where they could raise professional concerns, such as the NHS or GPhC. Pharmacy team members communicated with an open working dialogue during the inspection. They felt comfortable making suggestions to improve their ways of working.

Principle 3 - Premises ✔ Standards met

Summary findings

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

Inspector's evidence

The pharmacy was clean and well maintained. It was tidy and generally well organised. The pharmacy's floors and passageways were free from clutter and obstruction. It kept equipment and stock on shelves throughout the premises. And it had a private consultation room. Pharmacy team members used the room to have private conversations with people.

The pharmacy had a clean, well-maintained sink in the dispensary used for medicines preparation. It had a toilet, with a sink which provided hot and cold running water and other facilities for hand washing. The pharmacy maintained its heating and lighting to acceptable levels. The pharmacy's overall appearance was professional, including the pharmacy's exterior which portrayed a healthcare setting. The pharmacy's professional areas were well defined by the layout and were signposted from the retail area. Pharmacy team members generally prevented access to the restricted areas of the pharmacy.

Principle 4 - Services ✔ Standards met

Summary findings

Pharmacy team members manage and provide the pharmacy's services safely and effectively. The pharmacy suitably sources its medicines. It stores and manages its medicines appropriately. And it has some processes to help people understand and manage the risks of taking higher-risk medicines. But team members don't always maintain an audit trail of who is involved when dispensing, to help aid future reflection and learning.

Inspector's evidence

The pharmacy had ramped access from the street through an automatic door. Pharmacy team members could use the electronic patient medication record (PMR) system to produce large-print labels to help people with visual impairment take their medicines properly. And they gave examples of how they used written communication to help people with hearing impairment access their services and use their medicines safely.

The RP demonstrated how they recorded their consultations when providing services to people. This included capturing consent to share information with the person's GP. And they recorded the information provided to people so that they knew how to use their medicines effectively, and what to do if their symptoms did not resolve. Pharmacy team members were also sometimes able to refer people who requested a service to pharmacists who worked remotely at the company's head office. Team members explained they would refer people for a remote consultation if they were unable to come to the pharmacy. Or if the pharmacy was experiencing increased workload pressure. Remote consultations were performed by video call only. And team members established whether people could access a video call before referring them. If they could not, they were not suitable for referral for a remote consultation and were seen by the responsible pharmacist. The remote pharmacists recorded their consultations comprehensively using an electronic records system. The records gave clear information about the decisions they had made. And there was a clear audit trail of which professionals were responsible for each part of the person's journey through the service.

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 had printed materials available to provide to people to help them manage the risks of taking valproate. Pharmacy team members were aware of the requirements to dispense valproate in manufacturer's original packs. And they had access to prompts to help them have conversations with people about taking their valproate safely.

The pharmacy supplied medicines to a small number of 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 medicines on the backing sheets, so they could be identified in the pack. They provided people with patient information leaflets about their medicines each month. Team members documented any changes to medicines provided in packs.

The pharmacist routinely signed the "checked by" box on dispensing labels. But other pharmacy team members did not sign the 'dispensed by' boxes on dispensing labels during dispensing. This meant there

wasn’t a clear audit trail of the people involved in the dispensing process. Team members used dispensing baskets throughout the dispensing process to help prevent prescriptions being mixed up. The pharmacy delivered some medicines to people. It recorded the deliveries it made. The delivery driver left a card through the letterbox if someone was not at home when they attempted delivery. 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. But during the inspection, they were unable to find any records of regular temperature monitoring. The temperature in the fridge was within acceptable limits during the inspection. Pharmacy team members checked medicine expiry dates every three months, and they recorded their checks. They recorded medicines due to expire in the next twelve months on a sheet and they highlighted the packs. These items were removed from the shelves during their month of expiry. Pharmacy team members explained how they acted when they received a drug alert or manufacturers recall. But they did not record these actions.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide its services safely. It maintains its equipment properly, so it is safe to use. And pharmacy team members manage and use the equipment in ways that protect people's confidentiality.

Inspector's evidence

The pharmacy had the equipment it needed to provide the services offered. It also had reference resources available, including 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 to help prepare liquid medicines. 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.