General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Medicare Chemists, 8-10 Westgate, Honley, HUDDERSFIELD, West Yorkshire, HD9 6AA

Pharmacy reference: 1039630

Type of pharmacy: Community

Date of inspection: 18/09/2019

Pharmacy context

The pharmacy is in a row of shops in the centre of Honley. Pharmacy team members mainly dispense NHS prescriptions, including providing medicines to people in multi compartmental compliance packs. They sell a range of over-the-counter medicines. They offer services including medicines use reviews (MUR) and the NHS New Medicines Service (NMS). They provide a substance misuse service, including supervised consumption. The pharmacy provides various vaccinations to people, including seasonal flu and various travel vaccinations.

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 generally identifies and manages the risks associated with its services. It keeps the records required by law. Pharmacy team members know how to keep people's private information secure. And they know what to do if there is a concern about the welfare of a child or vulnerable adult. Pharmacy team members record and discuss some mistakes that happen. They sometimes use this information to learn and make changes to help prevent similar mistakes happening again. But, they don't always record enough detail about why these mistakes happen. So, they may miss opportunities to improve. The pharmacy has written procedures. But it does not regularly review these procedures. Not all pharmacy team members have read them or always follow them. So, they may not be working in the most effective way.

Inspector's evidence

The pharmacy had a set of standard operating procedures (SOPs) in place. The sample checked stated they were last reviewed in 2013. And, the next review had been scheduled for 2015. Pharmacy team members had read and signed the SOPs in 2013. But, they did not know if the procedures had been reviewed since 2013. A dispenser said they had read the SOPs in the last two years. And, they said they were asked to re-read the procedure approximately every two years. But, they did not record they had done so. The pre-registration pharmacist had been working at the pharmacy for approximately one week. And, he had not read the procedures, despite being fully engaged in dispensing activities. The pharmacy defined the roles of the pharmacy team members in each SOP. Each procedure was colour coded. And each colour represented different levels of qualification. For example, the steps that the pharmacist was responsible for was highlighted with one colour. And the steps that could be done by a dispenser were highlighted in another colour. But, the pharmacy had printed the procedures in black and white. So, the colour coding system could not be used. Pharmacy team members said they knew their roles from experience of working together and by discussion of tasks throughout the day.

The pharmacist highlighted and recorded near miss errors made by the pharmacy team when dispensing. Pharmacy team members discussed the errors made. But, they did not discuss or record much detail about why a mistake had happened. They usually said misreading the prescription had caused the mistakes. And, their most common change after a mistake was for the pharmacist to speak to staff to tell them what had happened and to encourage them to be more careful. The pharmacist analysed the data collected about mistakes every month. Once recorded, he sent the analysis to head office. And, he did not keep a copy to use for later reflection to establish if pharmacy team members had achieved their desired outcomes. In the example of the latest analysis available, the pharmacist based his analysis on quantitative information, such as how many mistakes had been made. And, how many of different types of mistakes, for example wrong strength or wrong quantity. He did not analyse for patterns of cause. The pharmacy had a process for dealing with dispensing errors that had been given out to people. It recorded incidents using a template reporting form. The examples seen gave information about what had happened. But, pharmacy team members had not recorded much information about why the mistake had happened. Or, what they had changed to prevent the mistake happening again. But, they gave a recent example of an error involving two look-alike and sound-alike (LASA) medicines. To prevent the mistake happening again, they had discussed the possible causes. And, they separated the medicines on the shelves to help prevent a future picking error.

The pharmacy had up-to-date patient group directions (PGDs) for the vaccination services being provided. But, they had not been signed by the pharmacist delivering the services. The pharmacist undertook physical vaccination training every two years. And, he had last completed training in 2018. He had also completed theoretical training for travel vaccinations in February 2019. And, he renewed this training every three years. The pharmacist explained he had carried out a visual risk assessment to make sure all necessary equipment was in place and the consultation room was safe for people. But, he had not documented the assessment. And, no other risks had been considered.

The pharmacy had a procedure to deal with complaints handling and reporting. It had a practice leaflet available for customers in the retail area which clearly explained the company's complaints procedure. It collected feedback from people by using questionnaires. But, some pharmacy team members said they had not seen any analysis from the questionnaires submitted. And, they could not give any examples of any changes they had made in response to people's feedback.

The pharmacy had up-to-date professional indemnity insurance in place. The pharmacy kept controlled drug (CD) registers complete and in order. It kept running balances in all registers. And they were audited against the physical stock quantity approximately monthly, including methadone. It kept and maintained a register of CDs returned by people for destruction. And it was complete and up to date. The pharmacy maintained a responsible pharmacist record on paper. And it was complete and up to date. The pharmacist displayed their responsible pharmacist notice to people. Pharmacy team members monitored and recorded fridge temperatures daily. They kept private prescription records in a paper register, which was complete and in order. And, they recorded emergency supplies of medicines in the private prescription register. They recorded any unlicensed medicines supplied, which included the necessary information in the samples seen.

The pharmacy kept sensitive information and materials in restricted areas. It shredded confidential waste. Pharmacy team members had trained to protect privacy and confidentiality. They had completed e-learning in March 2019. Pharmacy team members were clear about how important it was to protect confidentiality. But, the pharmacy did not have a documented procedure detailing the requirements under the General Data Protection Regulations (GDPR). And, there was no evidence that the pharmacy had been assessed for GDPR compliance.

When asked about safeguarding, a dispenser gave some examples of symptoms that would raise their concerns in both children and vulnerable adults. They explained how they would refer to the pharmacist. The pharmacist said they would assess the concern. And would refer to the superintendent pharmacist (SI) or local safeguarding teams for advice. The pharmacy had contact details available for the local safeguarding service. And, all pharmacy team members had completed training in 2018

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy team members have the right qualifications and skills for their roles and the services they provide. Pharmacy team members complete ad-hoc training. And, they learn from the pharmacist and each other to keep their knowledge and skills up to date. They reflect on their own performance. And, set objectives to improve their knowledge when they need to. Pharmacy team members feel comfortable discussing issues and act on ideas to support the effective delivery of services. But, the pharmacy owners are sometimes slow to respond when pharmacy team members raise issues.

Inspector's evidence

At the time of the inspection, the pharmacy team members present were a pharmacist, a pre-registration pharmacist, two dispensers and a delivery driver. Pharmacy team members completed training ad-hoc by reading various trade press materials. And, by completing occasional online training modules provided by head office and by having discussions in the pharmacy. They had completed the latest training module in May 2019, about children's oral health. The pharmacy had an annual appraisal process for pharmacy team members. A dispenser said they discussed their performance with the superintendent pharmacist (SI). And, they identified and discussed learning needs. They then set objectives to help improve. One example they gave of a recent objective was for them to complete their current pharmacy technician training course. The dispenser said they were being supported by the pharmacy and other colleagues to reach their objective.

A dispenser explained how they would raise professional concerns with the pharmacist or superintendent pharmacist (SI). They felt comfortable raising a concern. And, confident that their concerns would be considered. But they were less confident about how quickly changes would be made in response. One example was of them raising issues about one of the pharmacy fridges several times over the last few months. Staff at head office had acknowledged the concern. But, the pharmacy was still waiting for feedback and for the situation to be resolved. The pharmacy did not have a whistleblowing policy.

The pharmacy team communicated with an open working dialogue during the inspection. A dispenser said they were told by the pharmacist when they had made a mistake. And, they discussed the error. The discussion did not always fully explore why they had made the mistake. Pharmacy team members explained a change they had made after they had identified areas for improvement. They had noticed frequent picking error being made by pharmacy team members. And, after discussion, they had identified that people were often picking stock by using the dispensing labels rather than the prescriptions, as instructed in the standard operating procedure. So, they changed the dispensing process so that team members were required to pick the medicines they needed before they generated the labels. Pharmacy team members explained that following the change, they had noticed a reduction in the number of near miss errors being made. The pharmacy owners and SI did not ask the team to achieve any targets.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy has suitable space for the health services provided. And, it has a room where people can speak to pharmacy team members privately. The pharmacy is generally maintained to the required standards and has a safe and effective workflow. But, some benches are cluttered and untidy, which can increase the risks of mistakes being made.

Inspector's evidence

The pharmacy was generally clean and well maintained. Most areas of the pharmacy were tidy and well organised. But, some floor and bench areas were cluttered and untidy. And, this reduced the amount of space available for dispensing. There was a safe and effective workflow in operation. And, clearly defined dispensing and checking areas. The pharmacy had a private consultation room available. Pharmacy team members used the room to have private conversations with people. The room was signposted by a sign on the door.

There was a clean, well maintained sink in the dispensary used for medicines preparation. There was a toilet, which provided a sink with hot and cold running water and other facilities for hand washing. Heat and light in the pharmacy was maintained to acceptable levels. The overall appearance of the premises was professional, including the exterior which portrayed a professional healthcare setting. The professional areas of the premises were well defined by the layout and well signposted from the retail area.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy is generally accessible to people and it mostly manages its services safely and effectively. It sources its medicines from licenced suppliers. And it stores and manages its medicines appropriately. Pharmacy team members dispense medicines into devices to help people remember to take them correctly. They provide information with these devices to help people know when to take their medicines and to identify what they look like. Pharmacy team members take some steps to identify people taking high-risk medicines. And, they provide them with some advice. But, they don't always have written information for people to take away. So, people may not have all the information they need to help them take their medicines. And, they do not routinely maintain an audit trail of deliveries made to people. So, it might be difficult to deal with any queries or concerns.

Inspector's evidence

The pharmacy had stepped access from the street. It did not have a ramp or any signage to tell people how to get staff attention if they needed help getting in to the pharmacy. A pharmacy team member described an example of a patient who used a wheelchair. And, the person usually knocked on the pharmacy window and a member of the team went outside to help them. But, the person had to remain outside while pharmacy team members prepared their prescription. Pharmacy team members said they would make sure someone with a hearing impairment could see their lips to lip read. And, they would use written communication if necessary. Pharmacy team members had previously obtained labels printed in Braille for someone with visual impairment. They attached the Braille labels to the medicines alongside the legally required labels. And, they had ensured accuracy of the Braille by asking the person to read the Braille labels to them. The pharmacy had launched their annual flu vaccination service a week ago. It advertised the service to people by using posters in the pharmacy window. And, by word of mouth in the local community. Pharmacy team members said the service was already popular because no appointments were necessary. And, several people were seen asking for a vaccination during the inspection.

Pharmacy team members did not sign the dispensed by and checked by boxes on dispensing labels, despite being instructed to in the standard operating procedure (SOP) for dispensing. And, they did not maintain an audit trail of those involved in dispensing any other way. But, pharmacy team members said that when a mistake was made, the pharmacist raised it with the whole team. And, they freely confirmed who had been involved so they could have a discussion with the pharmacist about what had happened. This was discussed. And, pharmacy team members appreciated how useful a documented audit trail was to help identify those team members involved in dispensing. The pharmacy team used dispensing baskets throughout the dispensing process to help prevent prescriptions being mixed up. The pharmacy obtained medicines from four licensed wholesalers. It stored medicines tidily on shelves. And all stock was kept in restricted areas of the premises where necessary. It had adequate disposal facilities available for unwanted medicines, including controlled drugs (CDs). Pharmacy team members kept the CD cabinets tidy and well organised. And, out of date and patient returned CDs were segregated. The inspector checked the physical stock against the register running balance for three products. And they were found to be correct. The pharmacy supplied medicines in multi-compartmental compliance packs when requested. It attached labels to the pack, so people had written instructions of how to take the medicines. And it added the descriptions of what the medicines looked like, so they could be identified in the pack. Pharmacy team members provided people with patient

information leaflets about their medicines each month. And, they documented any changes to medicines provided in packs on the patient's electronic medication record.

Pharmacy team members checked medicine expiry dates every 12 weeks. And records were seen. They highlighted any short-dated items with a sticker on the pack up to three months in advance of its expiry. And they recorded expiring items on a monthly stock expiry sheet, for removal during their month of expiry. The pharmacy responded to drug alerts and recalls. And, any affected stock found was quarantined for destruction or return to the wholesaler. It recorded any action taken. And, records included details of any affected products removed. Pharmacy team members kept the contents of three pharmacy fridges tidy and well organised. They monitored minimum and maximum temperatures in two of the fridges every day. They recorded their findings. And, the temperature records seen were generally within acceptable limits. The pharmacy used the third fridge to store vaccinations. And, it had a thermometer installed to monitor temperatures. But, pharmacy team members were not monitoring or recording temperatures in the third fridge. This was discussed. And, pharmacy team members moved all stock out of the fridge and into the other two during the inspection. They gave an assurance that stock would only be moved back in to the third fridge when they had established it was maintaining temperatures within acceptable limits.

The pharmacist said he would counsel and provide information to people presenting a prescription for valproate who could become pregnant. He said he would check if they were enrolled on a pregnancy prevention programme with their GP. But, the pharmacist said he would not provide counselling information every time they received their prescription. And, the pharmacy did not have any printed material to provide to people to help them manage the risks. The pharmacist gave an assurance that a supply of materials would be obtained and that he would provide counselling to people with each supply. Pharmacy team members were aware of the requirements of the Falsified Medicines Directive (FMD). The pharmacy had the required scanners and software in place. And, the pharmacy had SOPs to incorporate the FMD scanning and checking process. But, the procedures were not being used. And, pharmacy team members confirmed that only the pharmacist had read them. They said they were not scanning all compliant packs. And, they explained they were often having difficulties accessing and using the software. So, they weren't always able to scan products. They said the issues had been raised with head office. But, the problems remained unresolved.

The pharmacy delivered medicines to people. It recorded the deliveries made. But, it did not ask people to sign to confirm they had received their deliveries, apart from deliveries containing CDs, which were signed for. 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 to arrange a re-delivery. The team highlighted bags containing CDs with a sticker on the bag and on the driver's delivery sheet. The pharmacy had a procedure in place for delivering medicines to people. And, the procedure instructed pharmacy team members to obtain a signature for all deliveries made. But, the pharmacy had no evidence that the delivery driver had read and understood the procedure. The pharmacist said the delivery driver worked at several of the company's branches. So, he may have read the procedure elsewhere. But, he did not know if that was the case.

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 confidentiality.

Inspector's evidence

The pharmacy had the equipment it needed to provide the services offered. The resources available included the British National Formulary (BNF), the BNF for Children, various pharmacy reference texts and use of the internet. The pharmacy obtained equipment from the licensed wholesalers used. And, it had a set of clean, well maintained measures available for medicines preparation. And, a separate set of measures to dispense methadone. The pharmacy positioned computer terminals away from public view. And, these were password protected. Pharmacy team members stored medicines waiting to be collected in the dispensary, also away from public view. The dispensary fridges were in good working order. And, pharmacy team members used them to store medicines only. They restricted access to all equipment and they stored all items securely.

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.