General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: SFK Lo Chemist Ltd, 29 Barnsley Road, Ackworth, PONTEFRACT, West Yorkshire, WF7 7HZ

Pharmacy reference: 1039880

Type of pharmacy: Community

Date of inspection: 12/06/2019

Pharmacy context

The pharmacy is in a suburb of Pontefract and next door to a medical centre. It dispenses NHS and private prescriptions. It supplies medicines in multi-compartmental compliance packs to help people take their medication. And it delivers medication 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	2.4	Good practice	The pharmacy team responds to feedback, makes suggestions and gets involved in improving services. The pharmacy team members identify and address their learning and development needs. They are comfortable sharing their errors and learning from their own and other people's mistakes.
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 the risks associated with its services. And it keeps most of the records it needs to by law. The pharmacy has written procedures for the team to follow. The pharmacy has adequate arrangements to protect people's private information. The pharmacy team members respond well when errors happen. And they discuss what happened and act to prevent future mistakes. The pharmacy reviews errors and acts to reduce common mistakes. People using the pharmacy can raise concerns and provide feedback. The pharmacy team responds to feedback to help improve the efficient delivery of pharmacy services. The pharmacy team has some level of training, guidance and experience to respond to safeguarding concerns to protect the welfare of children and vulnerable adults. But, while there are written prooedures for the team to follow, few team members have read the procedures. This means there is a risk they may not understand or follow correct procedures.

Inspector's evidence

The pharmacy had a range of up to date standard operating procedures (SOPs). These provided the team with information to perform tasks supporting the delivery of services. The folder containing the SOPs had an index and dividers separated the SOPs in to groups. So, the team could easily find the relevant procedure. Only one of the team had read and signed the SOPs signature sheets to show they understood and would follow them. The pharmacy had Indemnity insurance from the National Pharmacy Association (NPA) with an expiry date of 31 July 2019.

On most occasions the pharmacist when checking prescriptions and spotting an error asked the team member involved to find and correct the mistake. The pharmacy kept records of these errors and the team member involved wrote the entry. A sample of records looked at showed that the pharmacy team didn't always record the details about the prescription and dispensed item to help spot patterns. The record sometimes captured the team members learning and the actions they took to prevent similar errors. Examples from what had been recorded included when the team member had not shelf-checked their own work before the accuracy check. And that the team would double check the quantity before labelling. The team reviewed these records as part of a monthly patient safety review. The team linked most errors to medicines that sounded alike and had similar packaging. The team had placed alert notes on the shelves holding these products. So, the team members had a prompt to check the item selected. And they used the electronic patient medication record (PMR) to generate flash alerts to remind them to be vigilant when dispensing these products. The pharmacy kept electronic records of dispensing incidents. And printed them off for reference. The report detailed what had been prescribed and dispensed. Along with the reason for the error and the actions taken to prevent it from happening again. The pharmacy completed annual patient safety reviews. The latest annual report stated that the team members were to take more time when dispensing and checking prescriptions during busy periods. The team had asked people to leave 48 hours from ordering their repeat prescription and collecting their medicines. The team members introduced this after identifying that when people presented soon after requesting their prescription led to an increase in their workload pressure. And increased the risk of errors. The team had identified that people had often presented at the same time which created a large crowd in the retail area. Since introducing the change the team found the

workload pressure had reduced. And there was less crowding in the retail area. The report stated that the team had developed an improved audit trail for communications between the pharmacy and GP surgery. The report stated that the team was to use a memo between the pharmacy and GP surgery to reduce the risk of missing hospital discharges or changes to people's medication.

The pharmacy had a procedure for handling complaints raised by people using the pharmacy. And it had a poster providing people with information on how to raise a concern. The pharmacy team used surveys to find out what people thought about the pharmacy. The pharmacy published these on the NHS.uk website. The pharmacy had received complaints from people who couldn't get through on the telephone to order their prescriptions. In response, the pharmacy team directed people to the online system.

A sample of controlled drugs (CD) registers looked at found that they met legal requirements. The pharmacy had electronic CD registers. The system prompted the team when a stock check was due. And captured the current balance. The system also highlighted when the entry was a different quantity or strength to what had been entered before. The pharmacy recorded CDs returned by people. A sample of Responsible Pharmacist records looked at found that they mostly met legal requirements. But the time the pharmacist signed out as Responsible Pharmacist was not always recorded. The pharmacy kept an electronic record of supplies of medicines from private prescriptions. A sample of these records looked at found that occasionally the prescribers name was not correct. A sample of records for the receipt and supply of unlicensed products looked at found that they met the requirements of the Medicines and Healthcare products Regulatory Agency (MHRA).

The team had received training on the General Data Protection Regulations (GDPR). The pharmacy didn’t display a privacy notice in line with the requirements of GDPR. The team separated confidential waste for shredding.

The pharmacy team members had access to contact numbers for local safeguarding teams. The pharmacist manager and accuracy checking technician (ACT) had recently completed level 2 training from the Centre for Pharmacy Postgraduate Education (CPPE) on protecting children and vulnerable adults. The team had completed Dementia Friends training in 2017. The driver reported to the team any concerns they had about people they delivered medication to. The team responded when a person showed signs of confusion with their medicines. This included liaising with the person’s GP.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has a team with the qualifications and skills to support the pharmacy's services. The pharmacy offers team members opportunities to complete more training. And it provides feedback to team members on their performance. The team members share information and learning particularly from errors when dispensing. So, they can improve their performance and skills. The team members discuss how they can make improvements. And they agree new processes to support the safe and efficient delivery of the pharmacy services.

Inspector's evidence

The pharmacist manager covered most of the opening hours. The pharmacist manager from another branch in the company covered Saturdays. The pharmacy team consisted of a registered pharmacy technician who was also an accuracy checking technician (ACT), five qualified dispensers, three trainee dispensers, two new starters on the medicines counter assistant (MCA) training and a delivery driver. At the time of the inspection the pharmacist manager, the ACT, four qualified dispensers and two trainee dispensers were on duty. The company had a policy that all MCA would move on to dispenser training, unless the person objected to this. The pharmacist manager had developed a rota to ensure the team members completed key tasks. And for them to maintain their skills and knowledge across a range of roles.

The pharmacy provided extra training through e-learning modules. And it provided performance reviews to the team members. So, they had a chance to receive feedback and discuss development needs.The pharmacy didn't hold team meetings. The pharmacist manager spoke to each team member to ensure everyone was up to date with the latest information. Team members could suggest changes to processes or new ideas of working. One of the team had suggested changing the storage arrangements for the section holding prescriptions waiting to be collected. The team member spotted that there were many prescriptions in this section. And had suggested labelling the boxes holding the prescriptions alphabetically and into female and male names. The team members agreed and had implemented this. And they found it was easier to locate these prescriptions. The trainee dispensers had raised concerns about the amount of time they would have in the dispensary to develop their skills. As they still had responsibility for the retail area and pharmacy counter. The pharmacist manager had developed the team rota to provide the trainees with protected time in the dispensary.

The pharmacy had targets for services such as Medicine Use Reviews (MURs). There was no pressure to achieve them. The pharmacist offered the services when they would benefit people.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean, secure and suitable for the services provided. And it has good arrangements for people to have private conversations with the team.

Inspector's evidence

The pharmacy was clean, tidy and hygienic. It had separate sinks for the preparation of medicines and hand washing. The consultation room contained a sink and alcohol gel for hand cleansing. The team kept floor spaces clear to reduce the risk of trip hazards. The pharmacy had enough storage space for stock, assembled medicines and medical devices.

The pharmacy had a large, sound proof consultation room. The team used this for private conversations with people. The pharmacy had a notice in the retail area informing people of the availability of the consultation room. The retail area and pharmacy counter were large and provided space for the team to have private conversations with people.

The premises were secure. The pharmacy had restricted access to the dispensary during the opening hours. The pharmacy had a defined professional area. And items for sale in this area were healthcare related.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides services that support people's health needs. The pharmacy manages its services adequately. It keeps records of deliveries it makes to people, so, it can deal with any queries effectively. The pharmacy gets is medicines from reputable sources, and it has appropriate systems to store and manage medicines. But the team does not always refer to the prescription when dispensing and checking multi-compartmental compliance packs. So, there is a risk of supplying a person's medicines that doesn't match the prescription.

Inspector's evidence

People accessed the pharmacy via a ramp. The window displays detailed the opening times and the services offered. The pharmacy didn't have a leaflet with this information on and the contact details of the pharmacy for people to pick up and take away. The team had access to the internet to direct people to other healthcare services. The pharmacy kept a small range of healthcare information leaflets for people to read or take away. The pharmacy used a section of the retail area to raise awareness of mental health matters.

The pharmacy provided multi-compartmental compliance packs to help around 50 people take their medicines. The pharmacist assessed people requesting the service to see it would meet their needs. When the assessment revealed that the service would not suit the person the pharmacy team offered alternatives such as a paper record for the person to record when they'd taken their medicines. The pharmacy team colour coded the doses on the record to show the different times of day. People received monthly or weekly supplies depending on their needs. One of the qualified dispensers managed the service. And got support from others in the team. To manage the workload the pharmacy team divided the preparation of the packs across the month. The team usually received prescriptions in advance of supply. This allowed time to deal with issues such as missing items. Each person had a record listing their current medication and dose times. The team checked received prescriptions against the list and the backing sheet supplied with the packs. And queried any changes with the GP team. The pharmacy team dispensed the medicines in to the packs against the backing sheets, although the prescription was available. The team kept the empty packets of the dispensed medication. The accuracy checking technician (ACT) referred to the backing sheets and the empty packets when checking the packs. But didn't refer to the prescriptions at this point. The ACT marked the backing sheet to record a check against the empty packs. And placed a second mark after she'd checked the medicines in the pack. The team stored the packs to one side waiting for the downloaded prescription. The team downloaded the electronic prescriptions after dispensing and after the ACT had done their check. The ACT did a final check after the prescriptions were downloaded. And after the prescription had been clinically checked by the pharmacist. The ACT did their check with reference to the prescription and the backing sheet. Before marking the backing sheet to show completion of the checks. The ACT bagged the packs after completing all the checks. The team used a section of the main dispensary to dispense the medication. And the ACT had a dedicated section to complete their accuracy checking. Both areas were part of the main dispensary and close to the pharmacy counter. There was no space elsewhere in the pharmacy to use for these activities. The team tried to not disturb the dispenser when they were placing the medication in to the packs. The team members did not disturb the ACT when she was checking. The ACT didn't answer the telephone when she was checking. If the ACT had to break off from

checking the packs she marked the section of the pack she had reached to know where to re-start the check. The ACT counted the total number of medicines in the packs to match with the quantity listed on the backing sheet. The team recorded the descriptions of the products within the packs to help people identify their medicines. And supplied the manufacturer's patient information leaflets. The ACT had developed a form to record the team members involved with dispensing, accuracy checking and clinically checking the prescriptions and packs. The team completed the sections except for the clinical check by the pharmacist. The pharmacy received copies of hospital discharge summaries. The team checked the discharge summary for changes or new items. And liaised with the GP team asking for new prescriptions when required. The team kept the discharge summary for reference to if queries arose. The GP team used a form to advise the pharmacy team of changes to people's medication. The team managed changes to packs already sent to people by getting prescriptions to send new packs and getting the old ones back. Or sending enough medication in separate containers to cover until supply of the next packs.

The team asked people using the repeat dispensing service to allow 48 hours from requesting their next supply of medicines before collecting it. The pharmacy team used a form to advise GPs of products that were not available. And the alternates that they could prescribe. The team gave clear guidance to a person collecting medicine concerned that the pack looked different. The team explained that it was the same product, but the GP team had changed the brands prescribed. The pharmacy provided separate areas for labelling, dispensing and checking of prescriptions. The pharmacy team used baskets when dispensing to hold stock, prescriptions and dispensing labels. This prevented the loss of items and stock for one prescription mixing with another. The team used different coloured baskets to prioritise the dispensing and checking of prescriptions. The team members referred to the prescription when selecting medication from the storage shelves. The pharmacy team had completed checks to identify patients that met the criteria of the valproate Pregnancy Prevention Programme (PPP). This had not found anyone who fitted the PPP criteria. The pharmacy had the PPP information cards and leaflets to pass on to people. The pharmacy team had marked, using different colours, the packaging for eye drops used by a person with partial sight. So, the person knew which drops to use.

The pharmacy used clear bags to hold dispensed fridge lines. This allowed the team, and the person collecting the medication, to check the supply. The pharmacy used CD and fridge stickers on bags and prescriptions to remind the team when handing over medication to include these items. The pharmacy had a system to prompt the team to check that CD prescriptions were within the 28-day legal limit before making the supply. The pharmacy had checked by and dispensed by boxes on dispensing labels. These recorded who in the team had dispensed and checked the prescription. A sample looked at found that the team completed the boxes. The team member dispensing the medicines in to the multi-compartmental compliance packs dated and initialled the backing sheet. The ACT put prescriptions for the pharmacist to do a clinical check in a basket before she completed the final check. The pharmacist didn't record on the prescription or the audit sheet for the multi-compartmental compliance packs to show they had clinically checked the prescription. When the pharmacy didn't have enough stock of someone's medicine, it provided a printed slip detailing the owed item. And it kept a separate one with the original prescription to refer to when dispensing and checking the remaining quantity. The pharmacy kept a record of the delivery of medicines to people. This included a signature from the person receiving the medication. The pharmacy obtained separate signatures for CD deliveries.

The pharmacy team checked the expiry dates on stock. And kept a record of this. The last date check was on 15/05/19. The team used coloured stickers with the expiry date written on to highlight medicines with a short expiry date. And it kept a list of products due to expire each month. No out of date stock was found. The electronic CD register highlighted products that were due to expire. The team members usually recorded the date of opening on liquids. This meant they could identify products with a short shelf life once opened. And check they were safe to supply. The team usually recorded

fridge temperatures each day. A sample looked at found they were within the correct range. The pharmacy had medicinal waste bins to store out of date stock and patient returned medication. And it stored out of date and patient returned controlled drugs (CDs) separate from in date stock in a CD cabinet that met legal requirements. The team used appropriate denaturing kits to destroy CDs.

The pharmacy had 2D scanners and head office was arranging for a computer update to meet the requirements of the Falsified Medicines Directive (FMD). The team hadn't received any training. The pharmacy obtained medication from several reputable sources including Quantum Specials. And received alerts about medicines and medical devices from the Medicines and Healthcare products Regulatory Agency (MHRA) via email. The team printed off the alert, actioned it and kept a record.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide safe services. Medicines that require refrigeration are kept at the corect temperatures and safety checks on the electrical equipment are undertaken. Most of the time people's private infromation is protected. But the team doesn't always take the necessary steps to when the consultation room is in use. This means people may be able to see other people’s information.

Inspector's evidence

The pharmacy had references sources and access to the internet to provide the team with up to date clinical information.

The pharmacy used a range of CE equipment to accurately measure liquid medication. The pharmacy had a fridge to store medicines kept at these temperatures and it completed safety checks on the electrical equipment.

The computers were password protected and access to people's records restricted by the NHS smart card system. The pharmacy positioned the dispensary computers in a way to prevent disclosure of confidential information. The pharmacy stored completed prescriptions away from public view. And it held private information in the dispensary and rear areas, which had restricted access. The team used cordless telephones to make sure telephone conversations were held in private. The pharmacy kept tote boxes holding bags of completed prescriptions labelled with people’s names and addresses in the consultation room. And it kept completed consent forms containing people’s information in this room. This meant that people in the room could see other people’s information.

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.