General Pharmaceutical Council

# Registered pharmacy inspection report

**Pharmacy Name:** Pharmacy Plus Health, 13-15 Ryburn Buildings, SOWERBY BRIDGE, West Yorkshire, HX6 3AH

**Pharmacy reference:** 1039921

**Type of pharmacy:** Community

**Date of inspection:** 05/09/2024

## Pharmacy context

This pharmacy is located in a parade of shops in Sowerby Bridge. The pharmacy recently merged with another pharmacy, which was part of the same company. It mainly dispenses prescriptions and supplies some people with medicines in multi-compartment compliance packs to help them manage their medicines. The pharmacy also provides other services such as the NHS Pharmacy First, COVID-19 and seasonal flu vaccinations and the Hypertension Case-finding service.

## 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's working practices are safe and effective. It generally keeps the records it needs to keep by law, and they are kept accurate and up to date. The pharmacy team knows how to help protect the welfare of vulnerable people. However, they do not always adequately protect people's personal information.

### Inspector's evidence

Standard operating procedures (SOPs) were available electronically. They had been prepared and reviewed by the head office team. Team members were in the process of reading through the SOPs and the pharmacy manager provided an assurance that this would be completed soon. All team members had individual log in details to access SOPs relevant to their roles.

The company required the pharmacy to complete weekly compliance checks. This included the completion of controlled drug (CD) balance checks, fridge temperatures records, and responsible pharmacist (RP) logs.

Dispensing mistakes which were identified before the medicine was supplied to people (near misses) were recorded on an electronic system. A QR code was displayed which was used to access the system. The RP identified the team member who had dispensed the prescription and they were asked to identify their mistake and rectify it. Reviews of errors were completed informally. A new store-based pharmacist had started two weeks prior to the inspection, and he explained that he was due to complete a review of mistakes on a monthly basis. As a result of past mistakes, labels had been applied to the shelves where levothyroxine and losartan were kept to prompt team members to take care when picking these medicines from the shelf. And other medicines which 'looked-alike' and 'sounded-alike' had been separated. Any instances where a dispensing mistake had happened, and the medicine had been supplied to the person (dispensing errors) an investigation was completed. It was also discussed with the team and an electronic record was made. As a result of past dispensing incidents, the team had been asked to slow down when working and pharmacists had been asked to avoid checking medicines they had dispensed themselves.

The pharmacy had current professional indemnity insurance. There was a complaints procedure available. Complaints were discussed with the team and escalated to the superintendent pharmacist (SI) if needed. The pharmacy manager also checked online feedback and reviews that had been submitted. As a result of past feedback, people were sent a text message when their prescription was ready to collect. And the team used different wording when some medicines were not available to ensure the person was aware that everything was not ready to collect. The correct RP notice was displayed. When questioned, team members were aware of the activities that could not be carried out in the absence of the RP.

Emergency supply, RP records, controlled drug (CD) registers and records of unlicensed medicines supplied were well maintained. Running balances were recorded. A random balance was checked and found to be correct. Private prescription records did not all have details of the prescriber recorded. Which was required to show who had provided the authority to supply the medicine.

Assembled prescriptions that were ready to collect were stored behind the medicines counter and some confidential information was visible to people using the pharmacy. The pharmacy manager explained that this had been highlighted by a representative from the head office team who had visited the pharmacy the day before the inspection and the issue had been escalated to the SI. The head office team were in the process of sorting how prescriptions were stored. A tray containing medicines ready for delivery was within reach of people using the pharmacy. This was moved promptly when it was identified. The pharmacy had an information governance policy available, and its team members had completed training about it. The pharmacy separated confidential waste which was sent to head office for destruction. The RP had access to National Care Records (NCR) and obtained verbal consent from people before accessing it.

All team members had read the SOP for safeguarding. The RP had completed the Level two safeguarding training. If the team had concerns, they would refer to the RP and were aware of the next steps to follow. Signposting information was available.

## Principle 2 - Staffing ✔ Standards met

### Summary findings

The pharmacy has enough team members to manage its workload safely. And they work effectively together and support each other. Its team members are able to discuss pharmacy related issues as they arise and they are supported with their training courses.

### Inspector's evidence

The pharmacy team comprised of the RP, two trained dispensers, a pharmacy technician and the pharmacy manager who was an accuracy checking dispenser (ACD). The pharmacy had merged with another branch and most team members from the other site had been transferred. Other team members who were not present included another trained dispenser, trainee pharmacist and two delivery drivers. The pharmacy manager explained that there were enough team members to manage the workload. Holidays and absences were covered within the team, and they were able to get help from other branches under the same ownership if needed. A large volume of prescriptions were prepared at another branch within the same company, also called the hub pharmacy. This also helped to manage the workload.

Team members asked appropriate questions and counselled people before recommending over-the-counter medicines. They were aware of the maximum quantities of medicines that could be sold over the counter. There had been a lot of changes to the team within the last six months with the two branches merging. The pharmacy manager had been providing team members with verbal feedback but once the team were settled there were plans to conduct annual performance reviews.

The trainee pharmacist was provided with training time each week. To keep up-to-date, team members were given training material sent from head office and were given time to read through this at work. Team members were briefed on information about new services and were able to attend local training sessions if they wished. The team held weekly huddles and the head office team emailed updates to the pharmacy. The pharmacy manager attended a weekly manager meeting and passed on any relevant information to the team related to the operation of the pharmacy. The area manager visited the pharmacy fortnightly. Support had been provided to the RP who had recently started working in the pharmacy. This included another pharmacist within the company providing training on processes and ways of working. Targets were in place for services provided. The RP said targets would not affect his professional judgement in any way.

## Principle 3 - Premises ✔ Standards met

### Summary findings

The pharmacy's premises are clean, secure and provide an appropriate environment to deliver its services safely. People can have a discrete conversation with a team member in a private consultation room.

### Inspector's evidence

The premises were mostly clean and organised. The dispensary had ample working space and a separate area was used to manage and prepare multi-compartment compliance packs. The retail area was large which was tidy and clear of clutter. A sink was available for the preparation of medicines before they were supplied to people. Cleaning was done by members of the team. The room temperature and lighting were appropriate. The premises were kept secure from unauthorised access.

A clean, signposted consultation room was available and suitable for private conversations. Some confidential information was stored in the room but the pharmacy manager explained that people were not left unaccompanied and provided an assurance that access into the room from the shop floor will restricted.

## Principle 4 - Services ✔ Standards met

### Summary findings

The pharmacy largely provides its services safely. It obtains its medicines from licensed sources and manages them appropriately so that they are safe for people to use. It takes the right action in response to safety alerts so that people get medicines and medical devices that are safe to use.

### Inspector's evidence

The pharmacy was accessible from the street. The shop floor was clear of any trip hazards and the retail area was accessed easily. Team members assisted people who needed help entering the pharmacy. People were supplied with easy open bottles if requested. The pharmacy team were familiar with other services provided locally but also used the internet to signpost people who needed services that the pharmacy did not provide. Team members used electronic translation applications when needed.

The head office team monitored services that were being provided and team were encouraged to complete blood pressure checks, the New Medicine Service (NMS) and provide Pharmacy First services. A pharmacist from head office had been helping complete NMS consultations remotely.

There was an established workflow in place for dispensing and checking prescriptions. The pharmacy team initialled 'dispensed-by' and 'checked-by' boxes on dispensing labels to provide an audit trail. Prescriptions were checked for accuracy by either the RP or ACD. Any prescriptions that were suitable to be checked by the ACD were handed to him after they had been dispensed. The team used dispensing baskets to separate individual patients' prescriptions to avoid items being mixed up. The baskets were colour coded to help prioritise dispensing. Prescriptions that were sent to the pharmacy hub for dispensing were received the following day if the prescription data was sent over before a certain time.

The pharmacy team were aware of the risks associated with the use of valproate containing medicines during pregnancy. The pharmacy supplied one person with sodium valproate in a compliance pack. A written risk assessment had not been completed and the RP provided an assurance that he would do this. Additional checks were carried out when people were supplied with medicines which required ongoing monitoring.

Some medicines were dispensed in multi-compartment compliance packs. The pharmacy had reviewed all the people who used the compliance pack service and number of them had been switched to receive their medicines in original packs. Prescriptions were ordered by the pharmacy team. Individual records were available for each person which had a list of all their current medicines. New prescriptions were checked against the list and missing items were chased up with the surgery and a record was made on the system. The pharmacy did not routinely receive any communication from local hospitals if someone on a compliance pack was admitted. Instead the information was usually provided by the person, their family, carer or when a failed delivery queried. Information about changes to medicines was received as part of the Discharge Medicines Service. But on some occasions, there was a delay in receiving the information. The pharmacy manager explained that this had improved recently. Some packs were seen to be stored unsealed, with the lids closed on the shelves whilst they were waiting to be checked. Team members agreed that there were risks involved in doing this and would review how these were stored. Assembled compliance packs were seen to be labelled with product descriptions and patient

information leaflets were supplied each month. Mandatory warnings were missing from the packs, which could mean that people do not have all the information they need about their medicines. The pharmacy manager provided an assurance that he would speak to the computer system helpdesk and have the settings changed.

Before the launch of the NHS Pharmacy First service the RP had attended webinars and read the associated guidance. Training on using an otoscope had been covered as part the training for the ear wax removal service. The pharmacy manager felt that the seasonal flu and COVID-19 booster vaccination services had the most impact on the local population. This was because there were no other local pharmacies providing the COVID-19 booster vaccine service.

The pharmacy had delivery drivers who were based at the head office and carried out deliveries. An electronic system was used to audit deliveries. All deliveries were scanned into the system, and this was updated as medicines were delivered. The drivers took photographs when medicines were delivered. Unsuccessful deliveries were returned to the pharmacy.

Medicines were obtained from licensed wholesalers and were stored appropriately. Medicines were stored in a tidy and organised manner. Fridge temperatures were monitored daily and recorded which were seen to be within the required range for the storage of cold chain medicines. And CDs were kept securely. Expiry date checks were completed by the team every month and Short-dated stock was marked with stickers. No date expired medicines were found on the shelves checked. Obsolete medicines were disposed of in appropriate containers which were kept separate from stock and collected by a licensed waste carrier. MHRA drug recalls were received via email and on the electronic system, these were discussed with the team and actioned. The system was updated once the alert had been actioned.

## Principle 5 - Equipment and facilities ✔ Standards met

### Summary findings

Members of the pharmacy team have access to the equipment and facilities they need for the services they provide. The pharmacy uses its equipment to help protect people’s personal information.

### Inspector's evidence

The pharmacy had calibrated glass measures and tablet counting equipment was available. Separate measures were used for liquid CDs and separate triangles for cytotoxic medicines to avoid cross contamination. Two medical fridges were available. Up-to-date reference sources were available including access to the internet. The pharmacy's computers were password protected and screens were not visible to people using the pharmacy.

## 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. |