General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: SKF Lo (Chemists) Ltd, Unit 7 Sandal Castle Centre, Asdale Road, Sandal, WAKEFIELD, West Yorkshire, WF2 7JE

Pharmacy reference: 1039929

Type of pharmacy: Community

Date of inspection: 13/03/2024

Pharmacy context

This community pharmacy is near a medical centre in a suburb of Wakefield. The pharmacy dispenses NHS prescriptions and sells over-the-counter medicines. It supplies several people with their medicines in multi-compartment compliance packs to help them take their medication correctly. And it delivers medicines to some people's homes. The pharmacy provides other NHS services including the Pharmacy First service 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 identifies and manages the risks associated with its services well. It has up-to-date written procedures that the team members follow to help ensure they provide the pharmacy's services safely. And it keeps the records it needs to by law. Team members suitably protect people's confidential information, and they clearly understand their role to help protect vulnerable people. Team members respond appropriately when mistakes happen by identifying what caused the error and acting to prevent future mistakes.

Inspector's evidence

The pharmacy had a range of up-to-date standard operating procedures (SOPs) that provided the team with information to perform tasks supporting the delivery of its services. Team members had read the SOPs and signed the SOPs signature sheets to show they understood and would follow them. And they demonstrated a clear understanding of their roles and worked within the scope of their role.

Team members were asked to find and correct errors spotted at the final check of a prescription. The pharmacy kept records of these errors known as near miss errors. Team members were asked to complete the record after discussing the error with the pharmacist. A sample of near miss records showed sufficient details for team members to identify patterns, learn from the errors and take action to prevent similar errors. For example, one entry highlighted the team member was to take a mental break between dispensing different prescriptions especially when they were busy. There was a separate procedure for managing errors identified after the person received their medicine, known as dispensing incidents. This included completing a report and informing all team members so they were aware and could learn from it. Errors with medicines dispensed at the company's offsite pharmacy hub were recorded and reported back to the team at the hub. The pharmacist manager regularly reviewed the near miss records and dispensing incident reports and shared the outcome with the team. Recent reviews had resulted in team members separating medicines that looked alike and sounded alike to reduce the risk of the wrong medication being picked.

The pharmacy had a procedure for handling complaints raised by people using the pharmacy services. And information on the company's website provided details of how people could raise a concern. Following feedback from people the pharmacist manager advised team members to focus on acknowledging people when they initially presented at the pharmacy, especially at busy times. Team members were observed regularly doing this during the inspection.

The pharmacy had current indemnity insurance. A sample of records required by law such as the Responsible Pharmacist (RP) records, private prescriptions records and controlled drug (CD) registers met legal requirements. Appropriate records were kept of CDs returned by people for destruction which were promptly destroyed. The RP clearly displayed their RP notice, so people knew details of the pharmacist on duty. The pharmacist regularly checked the balance of CDs in the registers against the physical stock to identify any issues such as missed entries. A random balance check undertaken during the inspection was correct. To support the NHS Pharmacy First service the pharmacy had a range of patient group directions (PGDs). These provided the legal framework for the pharmacist to provide medication such as antibiotics. And they had been signed by the pharmacist to show they had read them, understood them and would follow them.

The company's website displayed details on the confidential data kept and how it complied with legal requirements to protect people's private information. Team members had completed training about the General Data Protection Regulations (GDPR). They separated confidential waste and regularly shredded it using an onsite shredder. The pharmacy had safeguarding procedures and guidance for the team to follow. And team members had completed training relevant to their roles. Team members responded appropriately when safeguarding concerns arose about vulnerable people. The delivery driver reported concerns back to the team who took appropriate action such as contacting the person's GP. The pharmacy displayed information advising people it was part of the safe space initiative which supported people experiencing domestic abuse.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has a team with an appropriate range of experience and skills to safely provide its services. Team members work well together, and they support each other in their day-to-day work. They discuss ideas and implement new processes to enhance the safe and effective delivery of the pharmacy's services. The team members have opportunities to receive feedback and complete training so they can suitably develop their skills and knowledge.

Inspector's evidence

A full-time pharmacist manager and regular locum pharmacists covered the opening hours as RP. The pharmacy team consisted of three part-time dispensers, two full-time trainee dispensers and a part-time delivery driver. At the time of the inspection all team members except one of the trainee dispensers were on duty. Team members worked well together and knew how to undertake key tasks. A daily rota allocated tasks amongst the team. This ensured these tasks were completed regularly, especially at times when team numbers were reduced such as planned and unplanned absence.

The pharmacy regularly held team meetings when information such as near miss errors was discussed. The pharmacist manager generated a weekly bulletin on key topics for all team members to read. The bulletin also gave a weekly action point for the team to focus on. Team members were encouraged to give feedback or suggest changes to processes. For example, one suggestion was to focus on putting away the medicine stock delivered from the wholesaler as quickly as possible so the floor space was kept clear. This also helped the team prioritise the dispensing of prescriptions awaiting medicines that had been ordered. Team members had not received formal feedback on their performance for some time but regularly received informal feedback. The manager also used the weekly bulletin to praise team members.

Team members used company online training modules to keep their knowledge up to date. All team members had been trained or were completing training on taking blood pressure (BP) readings to support the NHS hypertension case finding service. In preparation for the launch of the NHS Pharmacy First service the pharmacist had received training from Community Pharmacy West Yorkshire and the Centre for Pharmacy Postgraduate Education. And they had completed additional training reflecting their specific roles such as diagnosing the conditions listed within the service and using an otoscope.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are clean, secure, and provide an appropriate environment for the services provided. It has suitable facilities to meet the needs of people requiring privacy when using its services.

Inspector's evidence

The pharmacy team kept the premises tidy and hygienic. There were separate sinks for the preparation of medicines and hand washing, and alcohol gel was also available for hand cleansing. Team members kept the work surfaces in the dispensary tidy and they 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 soundproof consultation room that the team used for private conversations with people and when delivering pharmacy services. There was also a separate, cordoned-off area of the pharmacy counter for private conversations with people. The pharmacy had restricted public access to the dispensary during the opening hours.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides a range of services which are easily accessible for people. Team members manage the pharmacy services well to help people receive appropriate care and to make sure people receive their medicines when they need them. The pharmacy obtains its medicines from recognised sources, and it stores them properly. The team regularly carries out checks to make sure medicines are in good condition and are suitable to supply.

Inspector's evidence

People accessed the pharmacy via an automatic door and a step-free entrance. The pharmacy kept a small range of healthcare information leaflets for people to read or take away. And the team provided people with information on how to access other healthcare services when required. They asked appropriate questions of people requesting to buy over-the-counter medicines to ensure the most appropriate product was supplied. And they knew when to refer requests to the pharmacist.

The NHS Pharmacy First service was popular, several people had presented at the pharmacy since the service was launched. The pharmacist manager had met with the team at the nearby GP surgery to advise about the service and highlight the criteria for referring people. The pharmacy clearly displayed information about the service in the retail area for people to see and included details of the medical conditions that could be treated. The team used a dedicated section of the dispensary to store the medicines that were supplied against the service criteria. And the shelves holding these medicines were labelled with the medical condition the medication would be used for. The NHS hypertension case finding service was well used and one person had been referred to their GP for further tests. Team members used a BP stamp on prescriptions to highlight people who may benefit from the service. And to prompt them to discuss the service with the person when handing over their medication.

The pharmacy provided multi-compartment compliance packs to help several people take their medicines. And also provided these packs to people living in a local care home. To manage the workload the team divided the preparation of the packs across the month. And ordered the prescriptions several days before supply to allow time to deal with issues such as missing items. The care home team was responsible for ordering the prescriptions each month for the people living in the care home. But details of what had been ordered was not sent to the pharmacy for the team to check that all the medicines had been prescribed. This could make it harder for the pharmacy team members to identify if all the medicines have been correctly prescribed. The team used a small room behind the pharmacy for dispensing the packs, this was away from the distractions of the main dispensary and the retail area. Each person had a record listing their current medication and dose times which team members referred to during the dispensing and checking of the packs. Completed packs were sent to the care home a few days before the next monthly cycle started. This gave the care home team time to check the supply and identify any missing medication. The team recorded the descriptions of the products within the packs and supplied the manufacturer’s packaging leaflets. So, people could identify the medicines in the packs and had information about their medicines. The pharmacy received copies of hospital discharge summaries via the NHS communication platform. The team checked the discharge summary for changes or new items and contacted the prescriber when new prescriptions were required.

The pharmacy sent several people’s repeat prescriptions to the company’s offsite hub pharmacy to be

assembled there. Team members advised people to order their repeat prescriptions several days before they needed them to allow time for them to be dispensed at the hub and returned to the pharmacy. Before sending the prescription information the team processed the prescriptions, and the pharmacist completed a clinical check. Some medicines such as CDs and items the person urgently needed were dispensed at the pharmacy to reduce risk. And to ensure people's medicines were ready when they needed them. Most dispensed prescriptions from the hub were returned to the pharmacy the following day and were supplied in a sealed bag with the person's details embedded on the bag. Team members matched any prescriptions dispensed at the pharmacy with prescriptions for the same person sent from the hub. And they used bar code scanning technology to record that the dispensed medicines had been returned from the hub.

Team members provided people with clear advice on how to use their medicines. They were aware of the criteria of the valproate Pregnancy Prevention Programme (PPP) including the requirement to supply original manufacturer's packs of valproate. And they reviewed people prescribed valproate to identify anyone who may meet the PPP criteria. The pharmacist spoke to people who met the criteria to ensure they were on the programme and had the appropriate advice and support. And they kept a record of these conversations on the pharmacy's electronic patient medication records (PMR).

The pharmacy provided separate areas for labelling, dispensing and checking of prescriptions. Baskets were used during the dispensing process to isolate individual people's medicines and to help prevent them becoming mixed up. Pharmacy team members initialled 'dispensed by' and 'checked by' boxes on dispensing labels, to record their actions in the dispensing process. The pharmacy used clear bags to hold dispensed CDs and fridge lines which allowed the team, and the person collecting the medication, to check the supply. When the pharmacy didn't have enough stock of someone's medicine, it provided a printed slip detailing the owed item. The computer on the pharmacy counter had access to the PMR so when a person presented the team could check what stage of the process their prescriptions was at. Following a team discussion, changes had been made to the storage of completed prescriptions. Small and large bags holding completed prescriptions were separated so they were easier to locate. The pharmacy sent people a text message advising them when their prescription was ready to collect. The text message was only sent when all the prescriptions sent to the hub and dispensed at the pharmacy were complete. The pharmacy kept a record of the delivery of medicines to people for the team to refer to when queries arose.

The pharmacy obtained medication from several reputable sources and team members followed procedures to ensure medicines were safe to supply. They regularly checked the expiry dates on stock and kept a record of this. Medicines with a short expiry date were clearly marked to prompt the team to check the medicine was still in date. No out-of-date medication was found. Team members recorded the dates of opening for medicines with altered shelf-lives after opening so they could assess if the medicines were still safe to use. They checked and recorded fridge temperatures each day and a sample of these records found they were within the correct range. The pharmacy had medicinal waste bins to store out-of-date stock and patient returned medication. CDs were stored securely and out-of-date CDs were separated and clearly marked. The pharmacy had medicinal waste bins to store out-of-date stock and returned medication. And there were appropriate denaturing kits to destroy CDs. The pharmacy received alerts about medicines and medical devices from the Medicines and Healthcare products Regulatory Agency (MHRA) via email. The alerts were appropriately actioned and all team members informed.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide its services safely. And it uses its equipment appropriately to protect people's confidential information.

Inspector's evidence

The pharmacy had reference sources and access to the internet to provide the team with up-to-date information. The pharmacy had equipment available for the services provided that included a range of CE equipment to accurately measure liquid medication. And two fridges to hold medicines requiring storage at these temperatures. The pharmacy computers were password protected and access to people's records restricted by the NHS smart card system. The computer on the pharmacy counter was positioned to prevent unauthorised access of information on the screen. Team members used cordless telephones to ensure their conversations with people were held in private. They stored completed prescriptions away from public view and they held other private information in the dispensary and rear areas which had restricted public access.

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.