General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Horbury Road Pharmacy Limited, 186 Horbury Road, WAKEFIELD, West Yorkshire, WF2 8BQ

Pharmacy reference: 1039945

Type of pharmacy: Community

Date of inspection: 23/01/2020

Pharmacy context

This community pharmacy is on a main road close to Wakefield city centre. The pharmacy dispenses NHS and private prescriptions. The pharmacy supplies some medicines in multi-compartment compliance packs to help some people take their medicines. And it delivers medication to people's homes. The pharmacy provides the seasonal flu vaccination service. And it provides a supervised methadone consumption service.

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	1.2	Good practice	The pharmacy team members act competently when errors happen. They record their errors and share them with each other. The team regularly reviews the errors made. And it uses this information to take appropriate action to help prevent similar mistakes happening again. The team ensures pharmacists who don't regularly work at the pharmacy are aware of common errors and the changes made by the team to prevent errors happening again.
2. Staff	Good practice	2.2	Good practice	The pharmacy is good at providing team members with opportunities to develop their knowledge. The pharmacy supports the team to complete their training by providing protected time. The pharmacy gives team members regular feedback on their performance. So, they can keep their skills and knowledge up-to-date.
		2.4	Good practice	The pharmacy supports an open and honest culture within the team. The team members are good at supporting each other in their day-to-day work. They openly discuss, share and review their errors so they can learn from them. The team members observe each other's work and provide feedback. So, each team member can reflect on their performance and identify improvements to the delivery of pharmacy services.
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 team identifies and manages the risks associated with its services. People using the pharmacy can raise concerns and provide feedback. The team members have training, guidance and experience to respond to safeguarding concerns. So, they can help protect the welfare of children and vulnerable adults. The pharmacy team members act competently when errors happen. They record their errors and share them with each other. The team regularly reviews the errors made. And it uses this information to take appropriate action to help prevent similar mistakes happening again. The pharmacy has appropriate arrangements to protect people's private information. And it keeps most of the records it needs to by law.

Inspector's evidence

The pharmacy had a range of up-to-date standard operating procedures (SOPs) produced by the Numark organisation. These provided the team with information to perform tasks supporting the delivery of services. The SOPs covered areas such as dispensing prescriptions and controlled drugs (CDs) management. The SOPs described the roles and responsibilities of the team. And each SOP listed the role in the team the SOP related to. The SOP folder included an index of the SOPs and the pharmacist manager used dividers to put the SOPs in to groups. This enabled the team to easily locate specific SOPs when required. All the team except the part-time pharmacist who had been in post a few weeks had read the SOPs and signed the SOPs signature sheets to show they understood and would follow the SOPs. The team members understood their role and showed competence in their role. They would refer queries from people to the pharmacist when necessary. The pharmacy had up-to-date indemnity insurance.

On most occasions the pharmacist when checking prescriptions and spotting an error asked the team member involved to find and correct the error. The pharmacy kept records of these near miss errors. The pharmacist manager found when locum pharmacists worked at the pharmacy the near miss log was rarely used. The pharmacist manager reminded the team of the importance of completing the near miss record so patterns with errors could to be identified. And the team could act to reduce these errors. The pharmacist spoke to the locum pharmacists who regularly worked at the pharmacy to remind them to complete the near miss record. A sample of the error records looked at found that the team recorded details of what had been prescribed and dispensed to spot patterns. But team members did not record what caused the error. The section detailing the actions taken by the team to prevent the error happening again recorded the same information, that the team member involved was spoken to. So, there was little evidence of individual reflection. The pharmacy team completed an electronic report for dispensing incidents. These were errors identified after the person had received their medicines. The pharmacist manager printed the report and kept the pack dispensed in error with the report for reference to in case queries arose. The pharmacist informed all the dispensary team of any dispensing incidents. So, all team members were aware and could learn from them. A sample of completed dispensing incidents looked at found that the pharmacist recorded the cause of the error. But the report did not detail the actions taken by the team to prevent the same error happening again. The team had separated the strengths of gabapentin after a dispensing error involving these medicines. The team had discussed a dispensing incident when the wrong type of a penicillin antibiotic liquid was supplied to a child. As a result, the team now highlight the age of the child on the prescription. And check with the pharmacist the antibiotic selected before preparing the medicine.

The pharmacist manager asked the team to look at the near miss error record each week. So, everyone was aware of the errors made that week. And asked the team for ideas on how to reduce errors when completing the monthly patient safety review. A recent review captured the discussions the team had about the risk of errors with new inhalers. The pharmacist identified that the team were not familiar with the medicine within the inhaler and the type of inhaler. So, had helped the team improve their knowledge of the new inhalers. And reminded the team members to always speak to the pharmacist when they were unsure about an item on a prescription. To help prevent dispensing errors. The review stated the team were having open discussions with each other and sharing knowledge with each other. The team separated medicines that were often involved with errors because they looked alike and sounded alike (LASA). For example, amlodipine and amitriptyline. The team members attached warning stickers to the shelves holding LASA medicines to prompt them to check the medicine selected when dispensing. And the team had separated LASA medicines. Team members highlighted to each other when putting stock away any new LASA medicines. The pharmacy completed an annual patient safety report. The latest report highlighted discussions amongst the team about LASA medicines to increase their knowledge of these medicines. And to understand the risks linked with these medicines. The pharmacist manager shared the result of the monthly review of the near miss errors with the regular locum pharmacists. And asked them to read the annual patient safety report.

The pharmacy had a procedure for handling complaints raised by people using the pharmacy. And it had a leaflet 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.

A sample of controlled drugs (CD) registers looked at found that they met legal requirements. The pharmacy regularly checked CD stock against the balance in the register. This helped to spot errors such as missed entries. The pharmacy recorded CDs returned by people. A sample of Responsible Pharmacist (RP) records looked at found that some entries did not have the time the pharmacist stopped being the RP. A few records of private prescription supplies did not have the correct prescriber recorded. Records of emergency supply requests met legal requirements. 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 displayed a privacy notice providing people with information on the confidential data held in the pharmacy and how this data was protected. The team separated confidential waste for shredding.

The pharmacy team members had access to contact numbers for local safeguarding teams. The pharmacist had completed level 2 training on 02 September 2019 from the Centre for Pharmacy Postgraduate Education (CPPE) on protecting children and vulnerable adults. The team had completed Dementia Friends training in 2019. The delivery driver reported concerns they had about people they delivered to. And the team took appropriate action such as reporting the concern to the person’s GP.

Principle 2 - Staffing ✔ Good practice

Summary findings

The pharmacy has a team with the qualifications and skills to support the pharmacy's services. The pharmacy is good at providing team members with opportunities to develop their knowledge. And it gives team members regular feedback on their performance. So, they can keep their skills and knowledge up-to-date. The pharmacy supports an open and honest culture within the team. And the team members are good at supporting each other in their day-to-day work. They openly discuss, share and review their errors. So, they can learn from them. And they identify improvements to the delivery of pharmacy services by sharing ideas.

Inspector's evidence

A full-time pharmacist manager covered most of the opening hours. A part-time locum pharmacist covered the rest of the opening hours. The pharmacy team consisted of a full-time trainee pharmacy technician, three part-time qualified dispensers, a pharmacy student who worked on a Saturday and a part-time delivery driver. At the time of the inspection the pharmacist manager, the trainee pharmacy technician, two dispensers and a pharmacy student on placement from Huddersfield University were on duty.

The trainee pharmacy technician was supported by others in the team and had protected time to complete their training. This was usually in the afternoon when the team had completed most of the daily tasks. The pharmacy provided extra training for all the team through e-learning modules released each month by the Numark organisation. The team members had protected time to complete the training.

The pharmacy held morning team meetings. The pharmacist manager spoke to the team about the impact they have on the safe delivery of pharmacy services by using tools such as the near miss error record. The pharmacist manager supported the team to discuss their own errors and to see the near miss error record as a learning tool, not a blame tool. The pharmacy provided performance reviews for the team. So, they had a chance to receive feedback and discuss development needs. The pharmacist manager encouraged the team to observe each other and provide feedback to each other about their compliance with procedures. Such as asking people for their name and address when handing over completed prescriptions to ensure the correct prescription was supplied. The team identified that some people did not understand why the team asked for this information and the person may not want to give this information. The team knew the importance of following this procedure. So, the feedback from observing each other when handing out the prescription included the manner in which the team member asked the person for their name and address so that it did not upset the person.

Team members could suggest changes to processes or new ideas of working. One of the dispensers suggested using the list of people who received the compliance packs to mark when the team had dispensed the packs and when the packs were supplied to the person. So, the team knew what stage the pack was at when queries arose. The team agreed to this and implemented the process. The pharmacy did not have targets for the services provided. The pharmacist offered the services when they would benefit people.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are clean, secure and suitable for the services provided. And it has good facilities to meet the needs of people requiring privacy when using the pharmacy services.

Inspector's evidence

The pharmacy had undergone a major refit since the last inspection. And it was finished to a high standard. The refit had provided the team with more dispensing space and storage space. 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 antibacterial gel for hand cleansing. The team kept floor spaces clear to reduce the risk of trip hazards.

The pharmacy had a large, sound proof consultation room. The team used this for private conversations with people. The pharmacy had a section of the pharmacy counter cordoned off. The pharmacy team used this for private conversations with people who did not want to use the consultation room. The premises were secure. The pharmacy had restricted access to the dispensary during the opening hours. The window displays detailed the opening times and the services offered. 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 team members manage the pharmacy services well. They identify issues that affect the safe delivery of services. And they act to address them. The team members keep records of prescription requests and deliveries made to people's home. So, they can effectively deal with any queries. The pharmacy gets is medicines from reputable sources. And it stores and manages medicines appropriately.

Inspector's evidence

People accessed the pharmacy via a step free entrance. 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 team used a section of the retail area to promote healthy living advice. An eye-catching display focused on the dry January campaign. And provided information such as the benefits of giving up alcohol and the number of calories linked with drinking alcohol. The pharmacy kept a range of medicines for palliative care. So, prescribers knew where to send the prescriptions for the person to promptly get a supply of the palliative care medicines.

The pharmacy provided multi-compartment compliance packs to help around 51 people take their medicines. The team members identified they had reached a maximum number of people to provide this service to. And to take on more people could risk the safe delivery of the service. So, the team decided to limit the service to people who already used the pharmacy for their medicines. The team explained this to people who asked about the service and signposted them to other pharmacies. People received monthly or weekly supplies depending on their needs. The trainee pharmacy technician managed the service. And got support from others in the team. To manage the workload the team divided the preparation of the packs across the month. The team usually ordered prescriptions one week before supply. This allowed time to deal with issues such as missing items. And the dispensing of the medication in to the packs. Each person had a record listing their current medication, dosage and dose times. The record included any medicines that were not in the packs such as inhalers. The team updated the record with information from the GP such as dose changes. The team checked received prescriptions against the medication list and queried any changes with the GP team. The team used a section to the rear of the dispensary to dispense the medication in to the packs. This provided some protection from the distractions of the retail area. The team recorded the descriptions of the products within the packs. And it supplied the manufacturer’s patient information leaflets. The team stored completed packs in baskets labelled with the person’s name. The pharmacy occasionally received copies of hospital discharge summaries. The team checked the discharge summary for changes or new items. And shared the discharge summary with the GP team with a request for prescriptions when required.

The pharmacy supplied methadone as supervised and unsupervised doses. And it prepared the methadone doses using the MethaMeasure pump. The MethaMeasure had one pump for the sugar free version of methadone and a separate pump for the original version. The pump was linked to a laptop that the pharmacist updated with the methadone doses on receipt of a new prescription. When the person presented at the pharmacy their record on the laptop was selected and the dose due measured out. The person could take their dose in the consultation room or at a section of the pharmacy counter that provided some privacy.

The team members provided a repeat prescription ordering service for people who struggled to order their prescriptions using the methods asked for the by local GP teams. The delivery driver took the repeat prescription request slips when delivering the person's medication. So, they could ask the person what medicines they wanted for the next supply and mark this on the repeat prescription slip. The driver reported back to the pharmacy team any signs of the person over ordering their medicines or not taking their medicines. The team used this information to check the previous supplies made to the person. And to see if the person was not ordering medicines that they should be regularly taking. The team usually ordered the prescriptions a week before supply and kept a record of the request. This gave time to chase up missing prescriptions, order stock and dispense the prescription. The team regularly checked the record to identify missing prescriptions and chase them up with the GP teams. The team passed on information to people from their GP such as the need to attend the surgery for a medication review.

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 members referred to the prescription when selecting medication from the storage shelves. The team members used this as a prompt to check what they had picked. The pharmacy team were aware of the criteria of the valproate Pregnancy Prevention Programme (PPP). And the pharmacy had a SOP covering PPP. The pharmacy had completed regular audits of the supply of valproate to check if anyone met the PPP criteria. And found no-one prescribed valproate that met the PPP criteria. The pharmacy had the PPP pack to provide people with information when required. The team asked people on other high-risk medicines such as warfarin for information such as latest test results and doses. And recorded this information on to the electronic patient medication record (PMR).

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 stickers had a section to record the date the supply should be made by to prompt the team to check it was within the 28-day legal limit. But a sample of completed prescriptions awaiting supply did not have the date recorded. The pharmacist manager had spoken to the team about the 28-day legal limit and highlighted any CDs on the prescriptions. 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. When the pharmacy didn't have enough stock of someone's medicine, it usually provided a printed slip detailing the owed item. And 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 team checked the expiry dates on stock. And kept a record of this. The last date check was on 02 January 2020. The team used 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. The team members checked the expiry dates on receiving medicines sent from the wholesaler. And when they found medicines with short expiry dates, they arranged for the return of the stock. No out-of-date stock was found. The team members 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. For example, an opened bottle of morphine oral solution with 90 days use once opened had a date of opening of 16 January 2020 recorded. The team 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 procedures, scanning equipment and a computer upgrade to meet the requirements of the Falsified Medicines Directive (FMD). But the scanning equipment was faulty as it did not recognise the FMD compliant products. The pharmacist manager had reported this. The pharmacy obtained medication from several reputable sources. 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 usually kept a record. All the team members could access the email, so they could see the alerts and take prompt action.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide safe services. And the team mostly uses the pharmacy's facilities and equipment in a way to protect people's private 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 pharmacist checked the MethaMeasure methadone pump for accuracy each morning. The pharmacy had a large fridge to store medicines kept at these temperatures.

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. And it kept the computer screen in the consultation room locked when it was not in use. The pharmacy stored completed prescriptions away from public view. And it mostly held private information in the dispensary and rear areas, which had restricted access. But some completed consent forms containing people's confidential information for services such as the New Medicines Service were found on open the shelves in the consultation room. The team used cordless telephones to make sure telephone conversations were held in private.

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.