General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Scott Road Pharmacy, Scott Road, SELBY, North Yorkshire, YO8 4BL

Pharmacy reference: 1080013

Type of pharmacy: Community

Date of inspection: 19/11/2019

Pharmacy context

This community pharmacy is next door to a medical centre in the large town of Selby. The pharmacy dispenses NHS and private prescriptions. And it supplies multi-compartment compliance packs to help people take their medicines. The pharmacy delivers medication to people's homes. And it provides a supervised methadone consumption service.

Overall inspection outcome

Standards not all met

Required Action: Improvement Action Plan

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 not all met	2.2	Standard not met	Not all pharmacy team members are enrolled on a qualification training course relevant to their role. And in accordance with GPhC minimum training requirements.
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 mostly identifies and manages the risks associated with its services. People using the pharmacy can raise concerns and provide feedback. The team responds appropriately when people using the pharmacy services raise concerns. The pharmacy has written procedures that the pharmacy team follows. But not all the procedures have been recently reviewed. This means there is a risk that team members may not be following up-to-date procedures. The pharmacy team members respond adequately when errors happen. And they discuss what happened and they usually act to prevent future mistakes. But they regularly don't record all errors, or the actions taken to prevent errors. This means the team may miss opportunities to help identify patterns and reduce mistakes. The team members know the importance of keeping people's private information secure as they complete relevant training. But they store confidential waste in areas of the pharmacy people can access. The pharmacy keeps most of the records it needs to by law.

Inspector's evidence

The pharmacy had a range of standard operating procedures (SOPs). 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. Some SOPs had review dates due at the end of December 2015. Other SOPs had review dates in 2017. But the Superintendent Pharmacist had not completed the reviews. Most of the team had signed the SOPs to say they had read, understood and would follow the SOPs. But the SOPs signature sheets did not have the date when the team members had signed the sheets. So, there was no information to show how recently the team had read the SOPs. The member of the team in post for a few months had not signed the SOPs signature sheet. The pharmacy had up-to-date indemnity insurance.

The pharmacist when checking prescriptions and spotting an error told the team member involved of the mistake. Rather than asking the team member to find and correct their error to give them an opportunity to reflect on the mistake. The pharmacy kept two types of records of these near miss errors. One record the team used for near miss errors not classified by the team as serious. There was no guidance for the team to know when to classify the near miss as serious. These records had little information, there was no date when the error happened, only the month it happened in. And there were no details of what had been prescribed and dispensed to spot patterns. These near miss error records were also missing information such as what caused the error, the team members' learning from it and actions they had taken to prevent the error happening again. The team members used the other type of near miss records when they thought the error had serious potential. These records captured the date of the error, and the actions taken by the team to prevent the error from happening again. But these records did not capture the reason for the error. A sample of both types of error reports looked at found very little reporting of near miss errors. The pharmacy was trialling an electronic system of recording near miss errors and dispensing incidents. The pharmacy had one near miss error recorded on the electronic system since it started trialling the system in September 2019. The team had identified errors with the different strengths of amlodipine. So, had separated the strengths to reduce the risk of picking the wrong one. The pharmacy had used paper records for capturing dispensing incidents before trialling the computer system. One record detailed an error involving a missing medicine from the multi-compartment compliance packs supplied to a person. The report stated that the pharmacist had missed the note placed on the pack by one of the team advising of the missing medicine. The

pharmacist discussed the incident with the dispensary team members. And now they use larger, brightly coloured notes attached to the packs with Sellotape. So, the notes were easy to read and could not be removed.

The pharmacy had a procedure for handling complaints raised by people using the pharmacy. The pharmacy team used surveys to find out what people thought about the pharmacy. The pharmacy published these on the NHS.uk website though the last survey results on the NHS.uk website were dated 2016/2017. The team had received complaints from people about the seals used with multi-compartment compliance packs. People complained that the seals came off which ran the risk of losing their medicines. The pharmacist looked at packs made by another company and was replacing the old packs with the new versions.

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. So, the pharmacist could check to ensure the dispensed CD matched the prescription. The pharmacy recorded CDs returned by people. A sample of Responsible Pharmacist records looked at found that they met legal requirements. A sample of records of private prescription supplies found several entries did not have the prescribers' details recorded or were incorrect. The records of emergency supply requests looked at 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 pharmacist had provided the team with training on the General Data Protection Regulations (GDPR). The pharmacy did not display a privacy notice in line with the requirements of the GDPR. The team separated confidential waste for shredding onsite. A few persons collecting their medicines did not want their name and address said out loud by the pharmacy team. So, the team had adapted the questions it asked of people when handing over their prescriptions to check they were giving the medicines to the correct person. And recorded this request on the person's electronic patient medication record (PMR) so all the team were aware. The pharmacy team members had access to contact numbers for local safeguarding teams. The pharmacist had attended local training events on protecting children and vulnerable adults. The team had not done any Dementia Friends training or other specific safeguarding training.

Principle 2 - Staffing **Standards not all met**

Summary findings

Most of the pharmacy team members have the qualifications and skills to provide the pharmacy's services. But one team member, who dispenses medicines, is not enrolled on a training course as required for this role. The team members support each other in their day-to-day work. And they share information and learning particularly from errors when dispensing. The pharmacy provides the team members with some level of feedback on their performance. But they don't have opportunities to complete formal ongoing training. So, they may find it difficult to keep their skills and knowledge up to date.

Inspector's evidence

The pharmacist owner covered all the opening hours. And rarely had a day off. The pharmacy team consisted of a full-time dispenser, three part-time dispensers and a part-time delivery driver. One part-time member of the team had been in post for four months and was dispensing prescriptions. But they were not enrolled on to a training course. This team member had not read and signed the SOPs. But they appeared competent when dispensing medicines.

The pharmacy provided the team with limited extra training such as data protection. The pharmacy held team meetings as when information had to be shared with the team. The pharmacy did not provide formal performance reviews for the team. But the team members received informal feedback. This included positive comments from the GP teams that the pharmacist passed on to the team member involved. Team members could suggest changes to processes or new ideas of working. The pharmacy did not have targets for services such as Medicine Use Reviews (MURs). The pharmacist offered the services when they would benefit people.

Principle 3 - Premises ✔ Standards met

Summary findings

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

Inspector's evidence

The pharmacy was clean and hygienic. It had separate sinks for the preparation of medicines and hand washing. The pharmacy had recently received several boxes of non-medicinal stock from a care home for disposal. The team had placed the boxes by the fire exit whilst they were emptying the boxes. This meant there was a risk of team members tripping over the boxes if they were using the fire exit.

The pharmacy had a large, sound proof consultation room. The team used this for private conversations with people. The pharmacist invited people receiving their methadone doses into the consultation room for them take their medicines in private. But the team used the room as an office and store room. So, it was cluttered with paperwork and some medicine stock. 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 team provides services that support people's health needs and it manages its services appropriately. The pharmacy team takes care when dispensing medicines into multi-compartment compliance packs to help people take their medication. And it keeps its records about people's prescription collection requests up to date. So, this enables the team to deal with any queries effectively. The pharmacy obtains its medicines from reputable sources and it mostly stores and manages its medicines adequately. It delivers medicines to people's homes. But the driver doesn't always obtain signatures from people for the receipt of their medicines. So, the pharmacy doesn't have a robust audit trail and cannot always evidence the safe delivery of people's medicines.

Inspector's evidence

People accessed the pharmacy directly from the car park shared with the medical centre. The team had access to the internet to direct people to other healthcare services. And the pharmacy kept a small range of healthcare information leaflets for people to read or take away. The pharmacy supplied methadone as supervised and unsupervised doses. And it prepared the methadone doses in advance before supply. This reduced the workload pressure of dispensing at the time of supply. The pharmacy stored the prepared doses in the controlled drugs cabinet with some separation of each person's dose. To help reduce the risk of selecting the wrong one.

The pharmacy provided multi-compartment compliance packs to help around 100 people take their medicines. People received monthly or weekly supplies depending on their needs. Two of the qualified dispensers managed the service. To manage the workload the team divided the preparation of the packs across the month. The team usually ordered prescriptions two weeks 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 and dose times. The medication list had a notes section to record information such as dose changes. The team checked received prescriptions against the list. And queried any changes with the GP team. The dispensary was small with limited work space. The team used a small section at the rear of the dispensary to dispense the medication. This provided some protection from the distractions of the retail area. This section also had a computer. So, the team preparing the packs didn't have to disturb colleagues when labelling the packs and checking a person's medicines. The team recorded the descriptions of the products within the packs. And supplied the manufacturer's patient information leaflets. The pharmacy received copies of hospital discharge summaries. The team checked the discharge summary for changes or new items. And liaised with the GP teams to request prescriptions when required. So, the team could send out new packs. The team updated the medication list with new medicines or changes. The team had a dedicated communications book to record information received about people using the packs. For example, dose changes or new medicines.

The team members provided a prescription collection service. The team used a diary to record the date when the prescription would be available. The record included the person's name and the number of medicines ordered. So, the team could identify missing prescriptions and chase them up with the GP teams. The team members highlighted information printed on the repeat prescription slip such as when a medication review was due. So, they could pass this on to the person. The team also added this information to the bag labels. When handing the prescription over to the person the team member

pointed out the information rather than saying it out loud. So, other people in the pharmacy would not hear this. The pharmacy had recently introduced a Smart Phone App for people to order their repeat prescriptions. The team offered the App to people who enquired how to order their repeat prescriptions since the GP teams had removed the option for people to order their medicines over the telephone. Once logged in to the App the person scanned the bar code of each of their medicines to create a list. The person then marked each medicine they needed and sent the request to the GP team. The prescriptions were then forwarded to the pharmacy. The App system included a text message informing the person when their medicines were ready to collect from the pharmacy. The pharmacy team was aware of the criteria of the valproate Pregnancy Prevention Programme (PPP). And there were no people who met the criteria. The pharmacy had the PPP pack to provide people with information when required.

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 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 process to prompt the team to check that supplies of some CD prescriptions were within the 28-day legal limit. The team did not follow this process for all CDs. 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 only completed the checked by boxes. When the pharmacy didn't have enough stock of someone's medicine, it 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 section to capture the signature from the person receiving the medication. But the delivery driver regularly signed the records instead of the person receiving the delivery. So, there was nothing to prove that the driver had handed over the medication. And this was not in-line with the pharmacy's procedures.

A few tablets bottles containing loose medicines were found on the shelves in the dispensary. The bottles contained medicines removed from the multi-compartment compliance packs due to changes or errors made when dispensing. The tablet bottles were only labelled with the name of the medicine. The batch number and expiry date of the medicines were not recorded on the label. So, the team could not check these medicines against any safety alerts that came through. And the team couldn't include these medicines in any date checks. The pharmacy team checked the expiry dates on stock. But did not keep a record of this. The team used a coloured sticker to highlight medicines with a short expiry date. But four bottles of Septrin suspension with red dots on were found, all with the expiry dates of April 2019. 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. For example, an opened bottle of dexamethasone 2mg/5ml with three months use once opened had a date of opening of 21 October 2019 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 no procedures or equipment to meet the requirements of the Falsified Medicines Directive (FMD). And was waiting for the software provider to give a date for the computer upgrade to enable the team to comply with FMD requirements. 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 kept a record. The team kept a record of medicines that were out of stock at the wholesalers or ones the manufacturer could not supply. So, the team could keep the GP teams up to date with this information and discuss alternate medicines.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide safe services and it mostly uses its facilities 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. And used separate, marked measures for methadone. The pharmacy had two fridges to store medicines kept at these temperatures. Both fridges were full of medicine stock. So, the air flow that helped keep the fridges at the correct temperature may be affected.

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 had an NHS email address which allowed the team to share confidential information with the GP teams. The team used cordless telephones to make sure telephone conversations were held in private. And it held most private information in the dispensary and rear areas, which had restricted access. But the team stored a few baskets labelled with people's names holding completed multi-compartment compliance packs on the shelves in the consultation room. The pharmacy stored some completed prescriptions awaiting collection on hooks close to the pharmacy counter. The bag labels with people's names and address on were facing outwards. The consultation room was behind the pharmacy counter. And people using the room had to walk past the area where the team stored the completed prescriptions. So, people waiting near the pharmacy counter or walking past to get to the consultation room may see this information. During the inspection the pharmacist discussed the option of turning the bags around to hide the confidential 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.