General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Rotherham Road Pharmacy, 4 Rotherham Road, Great Houghton, BARNSLEY, South Yorkshire, S72 0DB

Pharmacy reference: 1085175

Type of pharmacy: Community

Date of inspection: 21/08/2019

Pharmacy context

The pharmacy is in a residential area in the village of Great Houghton. Pharmacy team members mainly dispense NHS prescriptions and sell a range of over-the-counter medicines. And, they offer services including medicines use reviews (MUR), the NHS New Medicines Service (NMS) and a stop smoking service. They provide a substance misuse service including supervised consumption. Pharmacy team members supply medicines in multi-compartmental compliance packs.

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	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 has procedures in place to identify and manage risks to its services. And, pharmacy team members have read the procedures relevant to their roles. Pharmacy team members generally know how to keep people's information secure. And they know what to do if there is a concern about the welfare of a child or vulnerable adult. The pharmacy keeps the records required by law. Pharmacy team members record and discuss some mistakes that happen. They use this information to learn and make changes to help prevent similar mistakes happening again. But, recently this has been infrequent. And, they don't always record enough detail about why these mistakes happen. So, they may miss opportunities to improve.

Inspector's evidence

The pharmacy had a set of standard operating procedures (SOPs) in place. And the pharmacy manager reviewed them regularly every two years. The sample checked were last reviewed in 2017 and 2018. And the next review was scheduled for 2019 and 2020. Pharmacy team members had read and signed the SOPs after the last review. The pharmacy defined the roles of the pharmacy team members in each procedure.

The pharmacist highlighted near miss errors made by the pharmacy team when dispensing. Pharmacy team members recorded their own mistakes. The pharmacy team discussed the errors made. But, they did not discuss or record much detail about why a mistake had happened. They usually said rushing or misreading the prescription had caused the mistakes. And, their most common change after a mistake was to double check next time. The pharmacist also said that recently, not all near miss errors had been recorded because the pharmacy was short staffed. And, there were very few mistakes recorded in 2019. The pharmacist or a nominated pharmacy team member carried out a review of the data collected every month. The last three months of reviews seen focussed on asking people to record their near miss errors to make improvements. There was little, or no analysis of the data that had been collected. But, pharmacy team members said that despite the lack of records, they had made some changes to prevent mistakes happening again. Their examples included creating a designated section in the dispensary for pain medication. And, they had separated commonly used look-alike and sound-alike (LASA) medicines, such as amlodipine and amitriptyline. The pharmacy had a process for dealing with dispensing errors that had been given out to people. It recorded incidents using a template report form and usually in a letter to the patient. The examples seen detailed what had happened and sometimes gave information about the causes of the mistakes, and what pharmacy team members had done to stop mistakes happening again.

The pharmacy had a procedure to deal with complaints handling and reporting. It had a practice leaflet available for customers in the retail area which clearly explained the company's complaints procedure. It collected feedback from people by using questionnaires. And, it had some information available from the last set of questionnaires to be analysed. One piece of feedback from people was about having somewhere available to speak to pharmacy team members privately. The pharmacy had two consultation rooms. And, they were signposted to people in the retail area. But, in responding to the feedback, pharmacy team members had noticed that if someone was speaking loudly in the consultation room nearest the retail counter, there was a risk they could be overheard. So, they decided to try and use the second room, furthest from the counter, especially if someone asked to

speak to them privately.

The pharmacy had up-to-date professional indemnity insurance in place. It kept controlled drug (CD) registers complete and in order. It kept running balances in all registers. And they were audited against the physical stock quantity at least monthly, including methadone. It kept and maintained a register of CDs returned by people for destruction. And it was complete and up to date. The pharmacy maintained a responsible pharmacist record on paper. And it was complete and up to date. The pharmacist displayed their responsible pharmacist notice to people. The pharmacy team monitored and recorded fridge temperatures daily. They kept private prescription records in a paper register, which was complete and in order. And, they recorded emergency supplies of medicines electronically. They recorded any unlicensed medicines supplied, which included the necessary information in the samples seen.

The pharmacy kept sensitive information and materials in restricted areas. It collected confidential waste in bin bags. The bags were sealed when they were full. And, these were segregated before being sent to another branch to be collected by a contractor and sent for secure destruction. But, the bags were not marked as confidential waste to prevent them from being mixed up with general rubbish. Pharmacy team members had been trained to protect privacy and confidentiality. The pharmacist had delivered the training verbally. One change they had made after learning about the General Data Protection Regulations (GDPR) in 2018 was the relocation of bags of medicines waiting to be collected. To help protect people's privacy, they moved the bags from behind the retail counter in to the secure area where medicines were prepared. Pharmacy team members were clear about how important it was to protect confidentiality. And there was a procedure in place detailing requirements under the General Data Protection Regulations (GDPR). But, some pharmacy team members were seen sharing their NHS smart cards to access electronic prescriptions. This was discussed. All pharmacy team members that required access to the NHS system had their own smart card. The pharmacist gave an assurance that pharmacy team members would use their own cards in future.

When asked about safeguarding, a dispenser gave some examples of symptoms that would raise their concerns in both children and vulnerable adults. They explained how they would refer to the pharmacist. The pharmacist said they would assess the concern. And would refer to local safeguarding teams for advice. The pharmacy had contact details available for the local safeguarding service. And, an SOP was available detailing what team members should do in the event of a concern. The pharmacist had completed training in 2018. But, other pharmacy team members had not been trained, other than from discussions with colleagues and experience from other roles outside the pharmacy. The advantages of training the whole team were discussed with the pharmacist.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy team members have the right qualifications and skills for their roles and the services they provide. Pharmacy team members complete ad-hoc training. And, they learn from the pharmacist and each other to keep their knowledge and skills up to date. They reflect on their own performance. And, set objectives to improve their knowledge when they need to. Pharmacy team members feel comfortable discussing issues and act on ideas to support the effective delivery of services.

Inspector's evidence

At the time of the inspection, the pharmacy team members present were a pharmacist manager, a pre-registration pharmacist, a trainee pharmacy technician, two NVQ level 2 dispensers and a delivery driver. Pharmacy team members completed training ad-hoc by reading various trade press materials and attending local training events. And by having regular discussions with the pharmacist and colleagues about current topics. The pharmacy had an appraisal process. A dispenser explained they had not had an appraisal for approximately two years. But, they discussed any learning needs with the pharmacist informally if necessary. The dispenser gave an example of a personal objective she had set after discussing needs with the team. She explained that she was less confident than her colleagues when using the pharmacy IT systems. So, she was working to obtain more experience and practice using the computer. And, she was being supported by the manager and other colleagues with training where needed.

A pharmacy team member explained that she would raise professional concerns with the pharmacist or superintendent pharmacist (SI). She said she felt comfortable raising a concern. And confident that her concerns would be considered, and changes would be made where they were needed. The pharmacy team communicated with an open working dialogue during the inspection. A dispenser said he was told by the pharmacist when he had made a mistake. The discussion that followed did not fully explore why he had made the mistake. But, he said he would always try and change something to prevent the mistake happening again.

Pharmacy team members explained a change they had made after they had identified areas for improvement. The had introduced two priority areas to store bags of medicines for delivery. They used one area to store bags for delivery locally. And, the other area was for medicines to be delivered further afield at a different time of the day. They explained this had helped them to prioritise which prescriptions to complete first. And, the new system had helped make sure prescriptions were ready for the driver and helped to prevent prescriptions for delivery being mixed up. The pharmacy owners and SI did not ask the team to achieve any targets.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy has suitable space for the health services provided. And, it has rooms where people can speak to pharmacy team members privately. The pharmacy is generally maintained to the required standards. But, some benches are cluttered and untidy, which increases the risks of mistakes being made.

Inspector's evidence

The pharmacy was clean and well maintained. It had a limited amount of bench space available for the volume of dispensing being done. And, some of this limited space was cluttered and untidy. But, the pharmacy had a safe and effective workflow in operation. And, clearly defined dispensing and checking areas. Pharmacy team members kept other areas of the pharmacy tidy and well organised. And the floors and passage ways were free from clutter and obstruction. It kept equipment and stock on shelves throughout the premises.

The pharmacy had two private consultation rooms available. Pharmacy team members used the rooms to have private conversations with people. And, the rooms were signposted by a sign on each door. There was a clean, well maintained sink in the dispensary used for medicines preparation. There was a toilet, which provided a sink with hot and cold running water and other facilities for hand washing. Heat and light in the pharmacy was maintained to acceptable levels. The overall appearance of the premises was professional, including the exterior which portrayed a professional healthcare setting. The professional areas of the premises were well defined by the layout and well signposted from the retail area.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy is accessible to people and it generally manages its services safely and effectively. It sources its medicines from licenced suppliers. And it mostly stores and manages its medicines appropriately. Pharmacy team members dispense medicines into devices to help people remember to take them correctly. They provide information with these devices to help people know when to take their medicines and to identify what they look like. Pharmacy team members take some steps to identify people taking high-risk medicines. And, they provide them with some advice. But, they don't always have written information for people to take away. So, people may not have all the information they need to help them take their medicines.

Inspector's evidence

The pharmacy was accessed via a ramp from the street. It had a bell and a sign to attract pharmacy team members' attention of people needed help getting in to the pharmacy. But, the bell was not working during the inspection. Pharmacy team members explained they could provide large-print labels to people who had a visual impairment. And, they would use written communication with someone with a hearing impairment.

Pharmacy team members signed the dispensed by and checked by boxes on dispensing labels. This was to maintain an audit trail of staff involved in the dispensing process. They used dispensing baskets throughout the dispensing process to help prevent prescriptions being mixed up. The pharmacy obtained medicines from eight licensed wholesalers via a buying group. It stored medicines tidily on shelves. And all stock was kept in restricted areas of the premises where necessary. It had adequate disposal facilities available for unwanted medicines, including controlled drugs (CDs). Pharmacy team members kept the CD cabinet(s) tidy and well organised. And, out of date and patient returned CDs were segregated. The inspector checked the physical stock against the register running balance for three products. And they were found to be correct. The pharmacy supplied medicines in multi-compartmental compliance packs when requested. It attached backing sheets to each pack, so people had written instructions of how to take the medicines. And, these included the descriptions of what the medicines looked like, so they could be identified in the pack. Pharmacy team members provided people with patient information leaflets about their medicines each month. And, they documented any changes to medicines provided in packs in various places. They recorded some information on the patient's master record. And, some on the patient's electronic medication record. Pharmacy team members also had a paper change record sheet available. But, they did not use the sheet consistently. The inspector discussed with the pharmacist the advantages of having a consistent approach to recording changes to people's medication.

Pharmacy team members checked medicine expiry dates every 12 weeks. And records were seen. They highlighted any short-dated items with a sticker on the pack up to three months in advance of its expiry. And they recorded expiring items on a monthly stock expiry sheet, for removal during their month of expiry. The pharmacy responded to drug alerts and recalls. And, any affected stock found was quarantined for destruction or return to the wholesaler. It recorded any action taken. And, records included details of any affected products removed. Pharmacy team members kept the contents of the pharmacy fridge tidy and well organised. They monitored minimum and maximum temperatures in the fridge every day. And they recorded their findings. The temperature records seen were within

acceptable limits.

The pharmacist said he would counsel and provide information to people presenting a prescription for valproate that could become pregnant. He said he would check if they were enrolled on a pregnancy prevention programme with their GP. But, the pharmacy did not have any printed material to provide to people to help them manage the risks. The pharmacist gave an assurance that a supply of materials would be obtained. Pharmacy team members were aware of the requirements of the Falsified Medicines Directive (FMD). The pharmacy had the required scanners and software in place. But, the explained they were having difficulties accessing and using the software. So, they were currently unable to scan products. Pharmacy team members had also not completed any training. The pharmacist said the training module was included in the inaccessible software. He said he had contacted the software supplier and the dialogue to have the issue resolved was ongoing.

The pharmacy delivered medicines to people. It recorded the deliveries made and asked people to sign for their deliveries. The delivery driver left a card through the letterbox if someone was not at home when they delivered. The card asked people to contact the pharmacy to arrange a re-delivery. The team highlighted bags containing CDs with a sticker on the bag and on the driver's delivery sheet.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the necessary equipment available, which it properly maintains. And it manages and uses the equipment in ways that protect confidentiality.

Inspector's evidence

The pharmacy had the equipment it needed to provide the services offered. The resources available included the British National Formulary (BNF), the BNF for Children, various pharmacy reference texts and use of the internet. Pharmacy team members obtained equipment from the licensed wholesalers used. And, they had a set of clean, well maintained measures available for medicines preparation. They used a separate set of measures to dispense methadone. The pharmacy positioned computer terminals away from public view. And, these were password protected. It stored medicines waiting to be collected in the dispensary, also away from public view. It had a dispensary fridge, which was in good working order. And, pharmacy team members used the fridge to store medicines only. Access to all equipment was restricted and all items were stored securely.

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.