General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Silkstone Pharmacy, 3 High Street, Silkstone, BARNSLEY, South Yorkshire, S75 4JH

Pharmacy reference: 1086719

Type of pharmacy: Community

Date of inspection: 25/06/2019

Pharmacy context

This is a community pharmacy in the village of Silkstone in Barnsley, South Yorkshire. The pharmacy sells over-the-counter medicines and dispenses NHS prescriptions. It also dispenses private prescriptions. The pharmacy team offers advice to people about minor illnesses and long-term conditions. And offers services including medicines use reviews (MURs), flu vaccinations and the NHS New Medicines Service (NMS). It also supplies medicines in multi-compartmental compliance packs to people living in their own homes.

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 adequate processes and written procedures to protect the safety and wellbeing of people who access its services. It keeps the records it must have by law and generally keeps people's private information safe. It is well equipped to protect the welfare of vulnerable adults and children. The pharmacy team members try to learn from any errors they make when dispensing. And they implement steps to make sure the errors are not repeated.

Inspector's evidence

The pharmacy had a set of standard operating procedures (SOPs) in place. These provided the team with information on how to perform tasks supporting the delivery of services. The SOPs covered procedures such as taking in prescriptions and dispensing. The team members were seen working in accordance with the SOPs. The pharmacy kept the SOPs in a ring binder. And an index was available, making it easy to find a specific SOP. The pharmacy defined the roles of the pharmacy team members in each SOP. The SOP showed who was responsible for performing each task. Pharmacy team members advised they would ask the pharmacist if there was a task they were unsure about. Or felt unable to deal with. The SOPs had been prepared in March 2014, but had not been reviewed since March 2016. And so, the SOPs may not have been up to date. All the team members had read and signed the SOPs that were relevant to their role in 2014.

The pharmacy had a process to report and record near miss errors that were spotted during dispensing. The pharmacist typically spotted the error and then informed the dispenser that an error had been made. The team members then discussed why the error had occurred. The error was then rectified by the dispenser and then passed to the pharmacist for another check. The team members sometimes recorded the details of the error into a near miss log. The details recorded included the date and time of the error. But they did not always record the reason why the error had happened. And so, they may have missed any common trends or patterns. The team members advised that they discussed errors that had been repeated more than once. For example, they had recently made a few near miss errors by mixing up prednisolone and propranolol. The team had put an alert sticker on the shelf edge where these medicines were stored, to remind the team to take extra care. The pharmacy had a process to report and record details of any errors that had reached a patient. These types of incidents were rare for the pharmacy. The most recent incident involved the person receiving an insulin cartridge instead of an insulin pen. The team had initially separated the two medicines to stop them being mixed up again. But they had returned to their original position.

The pharmacy did not advertise how a person could make a complaint or raise a concern. The resident pharmacist said that he would manage any complaints himself. The pharmacy organised an annual survey to establish what people thought about the service they received. But the results of the survey were not seen. And the team were unable to demonstrate how they had used the surveys to improve the service.

Appropriate professional indemnity insurance facilities were in place. The responsible pharmacist notice displayed the correct details of the responsible pharmacist on duty. Entries in the responsible pharmacist record complied with legal requirements. A sample of controlled drug (CD) registers were looked at and were found to be in order including completed headers, and entries made in

chronological order. Running balances were maintained. And they were checked at least once every two months. A random CD item was balance checked and verified with the running balance in the register. A CD destruction register for patient returned medicines was in place. The pharmacy kept records of supplies from private prescriptions. But several records had incorrect details of the prescriber. The pharmacy kept records of emergency supplies. But several records did not include the reason of why a supply was made. This is not in line with requirements. The pharmacy retained completed certificate of conformities following the supply of an unlicensed medicine.

The team held records containing personal identifiable information in staff only areas of the pharmacy. Confidential waste was placed into a separate bin to avoid a mix up with general waste. The confidential waste was destroyed periodically. The pharmacy had an information governance policy. And the team members had read and signed the policy.

The regular pharmacist and a pharmacy technician had completed training via the Centre for Pharmacy Postgraduate Education on safeguarding the welfare of vulnerable people. The pharmacy had several documents available that the team could use to manage a potential concern. These included a document on child protection and a flow chart of how to report a concern. The team also had access to the contact details of the local safeguarding team.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy employs enough team members to manage the services it provides. The team members complete training to ensure their knowledge and skills are refreshed and up to date. And they can raise professional concerns when necessary.

Inspector's evidence

The regular pharmacist was on duty at the time of the inspection. And was also the superintendent pharmacist. Another team member was supporting the pharmacist with the dispensing process. But the team member was not a fully qualified dispenser or enrolled on an approved training course. This was discussed with the pharmacist during the inspection. After the inspection the pharmacist successfully enrolled the team member onto an approved course. The pharmacy employed a pharmacy technician who was currently training to be an accuracy checking technician.

The pharmacist on duty supervised the team members. And they involved the pharmacist in offering advice to people who were purchasing over-the-counter products for various minor ailments. They carried out tasks and managed their workload in a competent manner. And they asked appropriate questions when selling medicines that could only be sold under the supervision of a pharmacist. The team members accurately described the tasks that they could and could not perform in the pharmacist's absence.
The pharmacy provided training time for the team members who were enrolled on a training course. The pharmacy technician generally completed her training on Fridays. The other team members were able to take time to read training material that was delivered to the pharmacy in the post. But the training was not structured. The team members had recently completed training on oral health.

The team held a meeting every two weeks. The team discussed topics such as company news, how to improve dispensing accuracy and could give feedback on how they could improve the pharmacy's services. They also discussed each other's near miss errors and shared the ways they could improve accuracy. For an example a team member suggested the team use a marker to check off the name, form and strength of the medicine they were dispensing. The team members said that this had improved their accuracy.

The team members could raise professional concerns by discussing them with the resident pharmacist. The pharmacy did not have a whistleblowing policy. And so, the team members may find it difficult to raise a concern anonymously.

The pharmacy did not set the team any specific targets to achieve.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is secure and adequately maintained. It has a sound-proof room where people can have private conversations with the pharmacy’s team members.

Inspector's evidence

The pharmacy was professional in its appearance. And was generally clean, hygienic and well maintained. Floor spaces were clear with no trip hazards evident. There was a clean, well-maintained sink in the dispensary for medicines preparation and staff use. There was a WC which had a sink with hot and cold running water and other facilities for hand washing. The area was free of clutter.

The pharmacy had a sound-proofed consultation room which contained adequate seating facilities. The room was smart and professional in appearance. The temperature was comfortable throughout the inspection. Lighting was bright throughout the premises.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides an appropriate range of services to help people meet their health needs. It generally stores, sources and manages its medicines safely. And it identifies and manages its risks adequately. The pharmacy team members help people to safely take high-risk medicines.

Inspector's evidence

The pharmacy was only accessible via several steps from the street which led to the entrance door. And so, it was difficult for people with mobility issues or pushchairs to enter the premises. The pharmacy building was listed. And so, the pharmacy was restricted in the way it could improve access. The team made sure they always watched the CCTV monitor which captured images of the steps. And they went to help anyone who was seen to have trouble using the steps. The services on offer, and opening times were advertised in the front window. Seating was provided for people waiting for prescriptions. Large print labels were provided on request. The team members had access to the internet. Which they used to signpost people requiring a service that the team did not offer. A wide range of healthcare related leaflets were available for people to select and take away.

Alert stickers were attached to prescriptions to alert the team to issues on hand out. For example, interactions between medicines or the presence of a fridge or a controlled drug that needed to be added to the bag. An audit trail was in place for dispensed medication using dispensed by and checked by signatures on labels. The dispensary had a manageable workflow with separate areas for the team members to undertake the dispensing and checking parts of the dispensing process. Baskets were available to hold prescriptions and medicines. This helped the team to stop people's prescriptions from getting mixed up. The team used different coloured baskets to indicate urgency and which prescriptions required delivery. The pharmacy had a procedure in place to highlight dispensed controlled drugs, that did not require safe custody. This helped the team ensure that the medicine could not be supplied to people after the prescription had expired. The team members were seen opening medicine bags and checking the contents before handing the bag to people. The team members said this was done as a final 'third' check to make sure people received the right medicines.

The pharmacy attached alert stickers to prescriptions to highlight people who were receiving high-risk medicines like warfarin. The team members showed these prescriptions to the pharmacist before they handed any medicines to people. And the pharmacist then gave these people additional counselling, if he felt there was a need to do so. But details of these conversations were not recorded on people's medication records. So, the pharmacy could not demonstrate how often these checks took place. INR levels were not always assessed. The team were aware of the pregnancy prevention programme for people who were prescribed valproate. The team said that they were aware of the risks. And they demonstrated the advice they would give people in a hypothetical situation. The team had access to literature about the programme that they could provide to people to help them take their medicines safely. The team did a check to see if any of their regular patients were prescribed valproate. And met the requirements of the programme. The team did not find any such people.

People could request multi-compartmental compliance packs. And these were supplied to people on either a weekly or monthly basis. The team were responsible for ordering the person's prescription. And they did this around a week in advance, so it had ample time to manage any queries. And then the

prescription was cross-referenced with a master sheet to ensure it was accurate. The team queried any discrepancies with the person’s prescriber. The team always checked with people if they required any items that they didn’t supply in the packs. The team recorded details of any changes, such as dosage increases/decreases, on the master sheets. The team supplied the packs with backing sheets which contained dispensing labels. And information which would help people visually identify the medicines. The team supplied patient information leaflets with the packs each month.

The pharmacy kept basic records of the delivery of medicines from the pharmacy to people. The records did not always include a signature of receipt. And so, an there was no audit trail that could be used to solve any queries. A note was posted to people when a delivery could not be completed. The note advised them to contact the pharmacy.

Owing slips were given to people on occasions when the pharmacy could not supply the full quantity prescribed. One slip was given to the person. And one kept with the original prescription for reference when dispensing and checking the remaining quantity. The team attempted to complete the owing the next day.

The pharmacy stored pharmacy only medicines behind the retail counter. These medicines could only be sold in a pharmacy, and under the supervision of a pharmacist. The storage arrangement prevented people from self-selecting these medicines.

The team checked the expiry dates of the stock every 3 months. And the team kept records of the activity. The team used stickers to highlight medicines that were expiring in the next 6 months. The team recorded the date the pack was opened on liquid medicines. This allowed them to identify medicines that had a short-shelf life once they had been opened. And check that they were fit for purpose and safe to supply to people. The pharmacy stored some loose medicines in unmarked bottles. And so, the pharmacy could not be certain if these medicines had not expired. This was discussed with the pharmacist during the inspection.

The team were not currently scanning products or undertaking manual checks of tamper evident seals on packs, as required under the Falsified Medicines Directive (FMD). No software, scanners or an SOP were available to assist the team to comply with the directive. The team had not received any training on how to follow the directive. The pharmacist said that he had ordered some scanners and had recently signed up with a software provided.

The pharmacy used digital thermometers to record fridge temperatures. A sample of the records were looked at. And the temperatures were always within the correct range. But the pharmacy did not record the temperatures each day. And so, it cannot be certain that the medicines stored in the fridge were fit for purpose on the days the temperatures were not recorded.

The pharmacy obtained medicines from several reputable sources. Drug alerts were received via email to the pharmacy and actioned. The alerts were stored for future reference. The pharmacy kept a record of the action taken following an alert.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy’s equipment is clean and safe, and the pharmacy uses it appropriately to protect people’s confidentiality.

Inspector's evidence

References sources were in place. And the team had access to the internet as an additional resource. The resources included hard copies of the current issues of the British National Formulary (BNF) and the BNF for Children. The pharmacy used a range of CE quality marked measuring cylinders. Tweezers and rollers were available to assist in the dispensing of multi-compartmental compliance packs. The fridge used to store medicines was of an appropriate size. Medicines were organised in an orderly manner. A blood pressure monitor was used. It was scheduled to be replaced every two years. Prescription medication waiting to be collected was stored in a way that prevented people’s confidential information being seen by members of the public. And computer screens were positioned to ensure confidential information wasn’t on view to the public. The computers were password protected. Cordless phones assisted in undertaking confidential conversations.

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.