General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Pickfords Pharmacy, 14 Main Street, Sprotbrough, Doncaster, South Yorkshire, DN5 7RF

Pharmacy reference: 1088410

Type of pharmacy: Community

Date of inspection: 17/09/2024

Pharmacy context

The pharmacy is in the village of Sprotbrough, on the outskirts of Doncaster in South Yorkshire. Its main services include dispensing NHS prescriptions, selling over-the-counter medicines and providing advice to people. The pharmacy provides a range of NHS consultation services including the Pharmacy First and blood pressure check service. It also provides seasonal flu vaccinations to people and offers a medicine delivery service to people's 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 adequately identifies and manages the risks for the services it provides. It has appropriate processes to support people in feeding back about its services. And it keeps people's confidential information secure. The pharmacy mostly keeps its records as required by law. Its team members have the knowledge to recognise, and report concerns to help keep vulnerable people safe from harm. And they engage in conversations to share learning and demonstrate how they act to reduce risk following the mistakes they make during the dispensing process.

Inspector's evidence

The pharmacy had standard operating procedures (SOPs) to support its safe and effective running. It held these digitally and team members knew how to access them. The review date for some SOPs such as those for managing and reporting mistakes made during the dispensing process were overdue for review. Other SOPs, such as one for managing the safe supply of valproate to people had recently been reviewed. Pharmacy team members discussed learning they had completed for the SOPs, but the pharmacy did not keep a record of this learning. They were observed completing dispensing tasks following details within the SOPs. They understood what tasks could not take place should the responsible pharmacist (RP) take absence from the pharmacy.

The pharmacy had a procedure for managing mistakes made and identified during the dispensing process, known as near misses. Pharmacy team members were encouraged to look again at their work following a mistake being identified and they worked to correct their own mistakes. But they did not always record their mistakes to support the pharmacy in identifying patterns and to inform risk management strategies. Team members demonstrated some actions they had taken to reduce risk following near misses. For example, separating different strengths of the same medicines on dispensary shelves by using dividers. And moving some medicines off dispensary shelves and into the dispensary drawers to help reduce the risk of mixing it up with a medicine that had a similar name. The pharmacy had a process for reporting mistakes that were identified following the supply of a medicine, known as dispensing incidents. The RP discussed how they would gather details of an incident, correct the mistake, and follow any onward reporting required such as to a person's GP. They stated they would then investigate the mistake further and complete a dispensing incident report. They could not recall having to manage a dispensing incident in the two years since working at the pharmacy and dispensing incident reports reflected this.

The pharmacy advertised how people could provide feedback about their experience at the pharmacy through scanning a quick response code on a poster at the medicine counter. Team members had a clear understanding of how to manage feedback and how to escalate a concern if local resolution was not possible. A team member explained how the most popular topic of feedback was about the availability of medicines. They demonstrated how the team established people's preferred contact method and took people's contact information to update them of stock availability if medicines were out of stock for a period of time.

The pharmacy had current professional indemnity insurance. The RP notice on display contained the correct details of the RP on duty. The RP record was generally kept in order but there were occasional

gaps in the record where a RP had not signed out when ceasing their role. A sample of the pharmacy's private prescription register, specials records and its controlled drug (CD) register found records to be made in accordance with legal and regulatory requirements. The pharmacy kept its CD register electronically. It kept records of running balances for all CDs and it undertook regular full balance checks of physical stock against the register balances. Random physical balance checks of CDs conducted during the inspection matched the running balances in the register. The team recorded patient-returned CDs in a separate register at the point of receipt.

Team members understood the importance of protecting people's confidentiality when providing pharmacy services. The pharmacy held people's confidential information in staff-only areas of the premises and on password-protected computers. It disposed of its confidential waste securely. The pharmacy had information available to support its team members in reporting safeguarding concerns. And team members had completed learning to support them in identifying these concerns. The pharmacy's delivery driver provided details of the action they took when they identified somebody may be vulnerable, and they were knowledgeable about the types of concerns they may come across in their role. The RP explained they would reach out to a peer for some support when reporting a safeguarding concern.

Principle 2 - Staffing ✔ Standards met

Summary findings

Pharmacy team members complete regular learning to support them in working safely and effectively in their roles. They are supportive of each other and communicate with each other effectively to manage the pharmacy's workload. And they know how to raise concerns at work. But the pharmacy does not always consider how best to use the skill mix of its team members when making changes to its services.

Inspector's evidence

The RP was the regular pharmacist and was working alongside a pharmacy technician (the pharmacy's manager) and a dispenser. A company-employed delivery driver was present for part of the inspection and the pharmacy employed another dispenser. There was some flexible working in the team to help maintain staffing levels during periods of leave. The team reported that there were odd days during periods of leave when only the RP and one other team member worked. Workload was up to date on the day of inspection and team members were observed communicating well with each other and working to prioritise urgent tasks. Team members were supportive of each other and worked together well. They shared examples of how they communicated with each other and with other pharmacies within the company. The pharmacy had a whistleblowing policy. Team members understood how to raise a concern at work. They explained they would bring any concerns they had to the attention of the pharmacy's operations manager or the superintendent pharmacist.

The pharmacy technician and a dispenser had completed extended learning to become accuracy checkers. But neither team member was working regularly in this role. The team explained this was due to workload changing as the company had moved dispensing activity for the multi-compartment compliance pack service to the company's local dispensing hub pharmacy. They also explained that reductions in staffing levels during periods of leave meant they were often directly involved in the dispensing process. Team members were aware that in these circumstances it would not be appropriate to self-check their work. The pharmacy had some targets for its services, and the team reported that these were closely monitored. The RP explained how they would apply their professional judgement when providing consultation services, but they stated they felt aware of workload in the dispensary building up when they were completing these services. Other team members had completed some learning to support in the delivery of some services, such as the NHS blood pressure check service. But the pharmacy had not reviewed its current workflow and skill mix to see how it could best use staff skill mix to support the delivery of all pharmacy services.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are clean, safe, and secure. They provide a suitable space for the pharmacy services provided. People using the pharmacy can speak with a member of the pharmacy team in a private consultation room.

Inspector's evidence

The pharmacy was secure and maintained to an appropriate standard. Team members knew how to raise any maintenance concerns with the premises. The pharmacy was clean and organised with no trip hazards identified. Lighting was sufficient throughout the pharmacy and heating and ventilation arrangements were appropriate. Pharmacy team members had access to sinks equipped with hand washing equipment and a dispensary sink provided access to fresh drinking water for use when preparing some liquid medicines.

The public area of the pharmacy was open plan with seating provided for people. The medicine counter provided a barrier between the public area and staff-only area of the pharmacy. The pharmacy's consultation room was to the side of the medicine counter and team members escorted people into and out of the room when using it for private consultations. The dispensary was on two levels with several steps separating the levels. The team mainly used the ground floor dispensary space for managing its day-to-day workload. The upstairs space had previously been used to assembly medicines in multi-compartment compliance pack. Team members reported they rarely used this space now. Staff break and toilet facilities were available onsite.

Principle 4 - Services ✔ Standards met

Summary findings

Pharmacy team members work effectively with other local healthcare providers to support timely access to healthcare services and medicines. And they provide relevant information to people when supplying medicines. The pharmacy obtains its medicines from reputable sources. It stores its medicines safely and securely. Overall, it manages its medicines appropriately through regular monitoring checks which help ensure they are stored within the right conditions and are safe to supply, but it does not always record these checks.

Inspector's evidence

The pharmacy was accessed at street level. Its window displays included information about its services and its opening times. Pharmacy team members had good knowledge of the local area and knew to signpost people to other pharmacies or healthcare services if they required a service or medicine the pharmacy could not provide. The team provided examples of how it worked with the local surgery to support people in accessing healthcare services and medicines. For example, it shared information about long term supply issues with the surgery team to help inform prescribing decisions. And the surgery referred people to the pharmacy for support and treatment for minor ailments.

The pharmacy provided NHS consultation services including the New Medicine Service, blood pressure check, contraception service and the Pharmacy First service. It had supportive information available to team members in providing these services, including clinical pathways, service specification and current patient group directions to support pharmacists in providing the Pharmacy First service. The regular pharmacist had signed these PGDs to support them in making a supply of a medicine following a consultation. The RP discussed some examples of people benefitting from accessing these services. This included people reporting that they found it convenient to seek repeat supplies of their routine contraceptive pill from the pharmacy directly, and timely treatment for people suffering from infected insect bites without the need to book a GP appointment. Team members were observed engaging well with people and providing relevant information when supplying medicines.

The pharmacy held its pharmacy (P) medicines behind the medicine counter. A team member explained how the team monitored repeat requests for higher-risk P medicines liable to abuse. And stated that people would be signposted to see their own GP if a pharmacist felt a repeat sale of these medicines was not appropriate. The pharmacy team was aware of some of the requirements of supplying medicines which required people to have a pregnancy prevention plan in place. But the RP was not aware of all of the checks they should make when supplying these medicines to a person in the at-risk group. A conversation highlighted the importance of bringing their knowledge up to date with the requirements of medicine-related pregnancy prevention programmes, including the potential need to provide advice to men about the use of valproate. The RP provided counselling and support when supplying other higher-risk medicines and medicines such as antibiotics. But they did not record these types of interventions to support them in providing continual care.

The pharmacy team used baskets throughout the dispensing process. This kept medicines with the correct prescription form. Team members identified their involvement in the dispensing process by applying their dispensing signatures to medicine labels. The pharmacy kept prescriptions for the

medicines it owed to people and team members referred to these prescriptions when dispensing the remaining quantity of a medicine. The delivery driver completed a digital record of the deliveries they made to people's homes. This information could be viewed in real-time by the pharmacy team to support it in answering any queries it received.

The pharmacy sent some of its work to the company's local dispensing hub pharmacy. The dispensing hub pharmacy assembled medicines in multi-compartment compliance packs and sent these back to the pharmacy for collection or delivery to people. The team demonstrated how they sent prescription data to the hub securely and provided an oversight of the process pharmacists followed to clinically check prescriptions and accuracy check the data prior to it being transferred to the dispensing hub pharmacy. The team had effective processes to ensure any locally dispensed medicines not dispensed inside the compliance packs was matched with compliance packs arriving back from the dispensing hub pharmacy.

The pharmacy sourced medicines from licensed wholesalers and a licensed specials manufacturer. It stored medicines neatly on shelves and in drawers and held them within their original packaging. The pharmacy held its CDs in secure cabinets, and it held medicines in a pharmaceutical fridge equipped with a thermometer. Team members explained they manually checked the minimum and maximum temperatures on the thermometer regularly. But they had not considered the need to record the operating temperature range of the fridge. They explained this was due to the thermometer being inbuilt into the fridge and an alarm sounding if the internal temperature of the fridge was outside of the required temperature range. They were knowledgeable about the required temperature range for storing cold chain medicines and knew how to investigate and raise concerns about temperature anomalies. A discussion highlighted the need to keep effective fridge temperature records to support the team in providing appropriate assurances that it was holding all of its cold chain medicines in a suitable environment.

The team recorded routine stock management checks it made to ensure its medicines were safe to supply to people. It clearly identified short-dated medicines to prompt additional checks during the dispensing process. It recorded the opening date on bottles of liquid medicines to help inform checks that any medicine remaining in the bottle was safe to supply. A random check of stock held in the dispensary found no out-of-date medicines. The pharmacy disposed of out-of-date and patient-returned medicines in medicine waste bins. Regular collections of these bins took place. The team received medicine alerts and drug recalls by email. The team demonstrated how it acted on these alerts by checking stock and following the actions stated within the alert.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs for providing its services. And pharmacy team members manage and use equipment in a way which protects people's confidentiality.

Inspector's evidence

Pharmacy team members had access to digital reference resources and the internet to support them in finding information and responding to queries. The pharmacy stored bags of assembled medicines in a designated area of the dispensary. This arrangement protected people's personal information on bag labels from being seen from the public area. It positioned its computer monitors facing into the dispensary to protect information on the screens from unauthorised view. Pharmacy team members used passwords and NHS smartcards to access people's medication records. They used a cordless telephone handset. This allowed them to move out of earshot of the public area when discussing confidential information over the telephone.

The pharmacy had a selection of CE marked measuring cylinders to measure liquid medicine. Equipment for counting medicines was readily available. It held some equipment to support the pharmacy's consultation services neatly within its consultation room. This equipment was from recognised manufacturers. But the team did not always include the consultation room when completing stock management tasks within other areas of the pharmacy to help ensure that equipment in the room remained safe to use. The pharmacy shared some equipment to support it in providing the NHS blood pressure check service with other pharmacies owned by the company. The pharmacy's electrical equipment was annotated with information which suggested electrical safety checks were due within the last month.

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.