General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: S T Shaw Pharmacy, Fartown Grange, Spaines Road, HUDDERSFIELD, West Yorkshire, HD2 2QA

Pharmacy reference: 1088446

Type of pharmacy: Community

Date of inspection: 11/03/2024

Pharmacy context

The pharmacy is adjacent to a GP surgery in the suburbs of Huddersfield. Pharmacy team members dispense NHS prescriptions and sell a range of over-the-counter medicines. The pharmacy provides services, such as the NHS Pharmacy First service. Team members provide medicines to people in multi-compartment compliance packs. And they deliver medicines 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 risks. It has the written procedures it needs relevant to its services to help team members provide services safely. Pharmacy team members understand their role to help protect vulnerable people. And they suitably protect people's confidential information. They record and discuss the mistakes they make so that they can learn from them. But they don't always capture key information, so they may miss some opportunities to learn and improve.

Inspector's evidence

The pharmacy had a set of standard operating procedures (SOPs) in place to help pharmacy team members manage risks. The superintendent pharmacist (SI) had reviewed the SOPs in 2023. And they were due to review them again in 2025. Pharmacy team members had signed to confirm their understanding.

The pharmacy provided the NHS Pharmacy First service to people. Pharmacy team members explained how the pharmacy had considered some of the risks of providing the service, such as the suitability of the pharmacy's consultation room to deliver the service from. And ensuring they had stock of the relevant medicines and the availability of the necessary equipment. They also ensured they had completed the necessary training and whether the pharmacy had the correct SOPs and supporting documents in place. The pharmacy displayed posters in the retail area explaining the service to people. These included information about each condition and how the pharmacy could help. Team members had created a document for them to refer to, which highlighted the key inclusion criteria for each condition covered by the service. They used the document as an aide memoire to help them appropriately refer people to the pharmacist for a consultation.

Pharmacy team members highlighted and recorded errors identified before people received their medicines, known as near miss errors. And dispensing errors, which were errors identified after the person had received their medicines. There were documented procedures to help them do this effectively. They discussed their errors and why they might have happened. And they gave some examples of changes they had made to help prevent isolated near miss errors from happening again. Team members did not always capture information about why the mistakes had been made or the changes they had made to prevent a recurrence to help aid future reflection and learning. The pharmacy had a process for analysing the information collected about errors. The responsible pharmacist (RP) analysed the data each month and submitted their findings to the company's head office. But they didn't keep a record of their analysis in the pharmacy to help the team make improvements to the pharmacy's services. And there were no examples of any changes they had made in response to the patterns they found. Pharmacy team members gave a clear explanation of how they would handle and record a dispensing error. And how they reported these errors to the superintendent pharmacist (SI). Examples of their records were available which provided some information about the errors. But again, team members did not capture much information about causes and the actions they had taken in response to each error to help aid future reflection and learning.

The pharmacy had a documented procedure for handling complaints and feedback from people. Pharmacy team members explained people usually provided verbal feedback and by completing questionnaires each year. And any complaints were referred to the pharmacist to handle. There was no

information available for people in the retail area about how to provide the pharmacy with feedback.

The pharmacy had current professional indemnity insurance. The pharmacy kept accurate controlled drug (CD) registers. It kept running balances for all registers. Pharmacy team members audited these balances each month. Checks of the running balances against the physical stock for three products were found to be correct. The pharmacy kept a register of CDs returned by people for destruction. It maintained a responsible pharmacist record electronically, and it was complete and up to date. The pharmacist displayed their responsible pharmacist notice. Pharmacy team members monitored and recorded fridge temperatures. The pharmacy kept private prescription and emergency supply records, which were complete and in order.

The pharmacy kept sensitive information and materials in restricted areas. It collected confidential waste in dedicated bags. The bags were sealed when full and collected approximately monthly by a waste disposal contractor for secure destruction. The pharmacy had a documented procedure in place to help pharmacy team members manage sensitive information. Pharmacy team members explained how important it was to protect people's privacy and how they would protect confidentiality. They completed an information governance checklist each year to confirm they were handling sensitive information correctly.

Pharmacy team members gave some examples of signs that would raise their concerns about vulnerable children and adults. And how they would discuss their concerns with the pharmacist, head office colleagues and the superintendent pharmacist. Team members were also aware of how to find information about key local safeguarding contacts by using the internet. The pharmacy had a documented procedure to help team members manage these concerns. Team members completed formal safeguarding training every two years.

Principle 2 - Staffing ✔ Standards met

Summary findings

Pharmacy team members have the right qualifications and skills for their roles and the services they provide. They complete regular training to help keep their knowledge and skills up to date. Pharmacy team members feel comfortable raising concerns and discussing ways to improve services.

Inspector's evidence

At the time of the inspection, the pharmacy team members present were a pharmacist and four qualified dispensers. Team members completed mandatory training modules approximately every three months and some ad hoc learning by reading various materials. Some recent examples of completed training topics included antibiotic awareness and domestic violence. Team members received an appraisal with their manager every year. They discussed their performance and set objectives to help achieve their goals. And they explained how they were supported to achieve their goals by the pharmacist and each other.

Pharmacy team members explained how they would raise professional concerns with the pharmacist, area manager or SI. They felt comfortable sharing ideas to improve the pharmacy or raising a concern. And they were confident that their concerns would be considered, and changes would be made where they were needed. The pharmacy had a formal whistleblowing policy. Team members knew where they could find this information on the company's intranet. And they were aware of organisations outside the pharmacy where they could raise professional concerns, such as the NHS or GPhC.

Team members communicated with an open working dialogue during the inspection. They felt comfortable making suggestions to improve their ways of working. They explained how they had recently changed the way they organised prescriptions with items owed to people. Their changes had improved the efficiency of the process, making the prescriptions easier to find and match up with stock when orders arrived in the pharmacy. The pharmacy asked team members to achieve various targets, mainly relating to the services they provided to people. The pharmacist received regular progress updates from their area manager. And the team were supported to meet their targets by a service support pharmacist if necessary.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean and properly maintained. It provides a suitable space for the services it provides. The pharmacy has a consultation room where people can speak to pharmacy team members privately.

Inspector's evidence

The pharmacy was clean and well maintained. It was tidy and generally well organised. The pharmacy’s floors and passageways were free from clutter and obstruction. It kept equipment and stock on shelves throughout the premises. And it had a private consultation room. Pharmacy team members used the room to have private conversations with people.

The pharmacy had a clean, well-maintained sink in the dispensary used for medicines preparation. It had a toilet, with a sink which provided hot and cold running water and other facilities for hand washing. The pharmacy maintained its heating and lighting to acceptable levels. The pharmacy’s overall appearance was professional, including the pharmacy’s exterior which portrayed a healthcare setting. The pharmacy’s professional areas were well defined by the layout and were signposted from the retail area. Pharmacy team members prevented access to the restricted areas of the pharmacy.

Principle 4 - Services ✔ Standards met

Summary findings

Pharmacy team members manage and provide the pharmacy’s services safely and effectively. The pharmacy suitably sources its medicines. And it generally stores and manages its medicines appropriately. The pharmacy’s services are easy for people to access. And it has some processes to help people understand and manage the risks of taking higher-risk medicines.

Inspector's evidence

The pharmacy had level access from the car park. Pharmacy team members could use the electronic patient medication record (PMR) system to produce large-print labels to help people with visual impairment take their medicines properly. And they gave examples of how they used written communication to help people with hearing impairment access their services and use their medicines safely.

The pharmacy had a large number of its prescriptions dispensed at the company's off-site dispensing hub pharmacy, where medicines were picked and assembled by a dispensing robot. Pharmacy team members explained that prescriptions were assessed to establish whether they were suitable to be sent to the hub pharmacy. They continued to dispense prescriptions for urgent items, such as antibiotics, medicines stored in the fridge and prescriptions for unusual quantities of medicines. They used the hub pharmacy most commonly for people's regular repeat medication. Pharmacy team members annotated on the electronic prescription token which items were being sent to the hub pharmacy and which items were for the team to dispense. The pharmacist performed a clinical and accuracy check of each prescription. Once the pharmacist authorised the prescription, it was released and sent to the hub pharmacy for assembly. The pharmacy received the medicines in sealed packages from the hub. Pharmacy team members matched the bags with the relevant prescriptions and dispensed any items that needed to be prepared in the pharmacy. And the bags were added to the prescription retrieval shelves ready for collection or delivery.

The pharmacist counselled people receiving prescriptions for valproate if appropriate. And they checked if the person was aware of the risks if they became pregnant while taking the medicine. They also checked if the person was on a Pregnancy Prevention Programme. The pharmacy had printed materials available to provide to people to help them manage the risks of taking valproate. Team members were aware of the requirements to dispense valproate in manufacturer’s original packs.

The pharmacy supplied medicines to people in multi-compartment compliance packs when requested. It attached backing sheets to the packs, so people had written instructions of how to take their medicines. Pharmacy team members included descriptions of medicines on the backing sheets, so they could be identified in the pack. They provided people with patient information leaflets about their medicines each month. The pharmacy was usually provided with information about changes to people’s medicines in writing from their GP. And team members documented these changes on the person’s PMR. Some people received valproate in their compliance packs, which meant that team members supplied the valproate outside of the manufacturers original packaging. Team members had continued to provide people with valproate in their compliance packs because that was how the person was used to receiving their medicines. And they had considered that changing to provide valproate in the manufacturers original box may introduce risk and cause confusion. But they had not discussed this

with other people involved in the person’s care, such as the person’s GP, to establish if this was the most appropriate action. And they had not documented their assessments to help manage future queries and adjustments.

Pharmacy team members signed the 'dispensed by' and 'checked by' boxes on dispensing labels during dispensing. This maintained an audit trail of the people involved in the dispensing process. They used dispensing baskets throughout the dispensing process to help prevent prescriptions being mixed up. The pharmacy delivered some medicines to people. It recorded the deliveries it made. The delivery driver left a card through the letterbox if someone was not at home when they attempted delivery. The card asked people to contact the pharmacy. Team members monitored any undelivered medicines and alerted the person’s GP if they were unable to make a delivery after attempts on three consecutive days. People were asked to sign to confirm receipt of specific CDs.

The pharmacy obtained medicines from licensed wholesalers. It had disposal facilities available for unwanted medicines, including CDs. Team members monitored the minimum and maximum temperatures in the pharmacy’s fridge each day and recorded their findings. The temperature records were within acceptable limits. Pharmacy team members checked medicine expiry dates every three months, and they recorded these checks. They highlighted items due to expire in the next six months by attaching a sticker to the pack. After a check of the shelves, the inspector did not find any out-of-date medicines. Pharmacy team members explained how they acted when they received a drug alert of manufacturers recalls.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the necessary equipment available for the services it provides. It manages and uses its equipment in ways that protect people's confidentiality.

Inspector's evidence

The pharmacy had the equipment it needed to provide the services offered. The resources it had available included the British National Formulary (BNF), the BNF for Children, various pharmacy reference texts and use of the internet. The pharmacy had a set of clean, well-maintained measures available for medicines preparation. It had suitable bags available to collect and segregate its confidential waste. It kept its password-protected computer terminals and bags of medicines waiting to be collected in the secure areas of the pharmacy, away from public view.

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.