General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Hill Top Pharmacy, 5 Headlands Lane, KNOTTINGLEY, West Yorkshire, WF11 0LA

Pharmacy reference: 1088561

Type of pharmacy: Community

Date of inspection: 27/10/2022

Pharmacy context

This pharmacy is in Knottingley town centre. The pharmacy's main activity is dispensing NHS prescriptions. It supplies some medicines in multi-compartment compliance packs to help people take their medication. And it delivers medicines to people in their homes. The pharmacy provides the NHS COVID-19 vaccination 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 not all met	1.6	Standard not met	The pharmacy's records for assuring it delivers its services safely and effectively are incomplete and inaccurate. It does not follow due process to investigate and account for discrepancies with its records of controlled drugs medicines.
2. Staff	Standards not all met	2.2	Standard not met	Not all pharmacy team members have a recognised training qualification. And they are not undergoing a recognised training course relevant to their role. This is not 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 not all met**

Summary findings

The pharmacy identifies and manages some of the risks associated with its services. But the records that help make sure it delivers its services safely are incomplete and inaccurate. And it does not follow due process to investigate and account for discrepancies with some of its records. The pharmacy has written procedures that team members mostly follow and it suitably protects people's confidential information. Team members respond adequately when errors happen, and they usually act to prevent future mistakes.

Inspector's evidence

The pharmacy had a range of up-to-date standard operating procedures (SOPs). These provided the team with information to perform tasks supporting the delivery of services. The team had read the SOPs but only two team members had signed some of the signature sheets to show they understood and would follow them. The pharmacy had an up-to-date SOP and risk assessment for the NHS COVID-19 vaccination service. They demonstrated a clear understanding of their roles and referred queries from people to the pharmacist when necessary.

The pharmacy had procedures to manage errors spotted during the dispensing process known as near miss errors. And it had separate procedures for errors that were identified after the person received their medicines, known as dispensing incidents. The procedures included keeping a record of the near miss errors. The pharmacy had a template to capture these errors but few records had been made. The records were completed by the pharmacist and showed similar details such as the error was corrected and the team member involved was to concentrate more. This meant there was little opportunity for the team members to reflect on their own errors and record their learning from it. The team members highlighted to each other medicines that looked and sounded alike. The telephone rang regularly throughout the inspection. The team reported many of the telephone calls were related to the COVID-19 vaccination service and prevented other calls from coming in or the team making outgoing calls. The team regularly had to break away from dispensing to answer the telephone which ran the risk of an error occurring. This had not been addressed as part of any learning to reduce errors. The pharmacy had a procedure for handling complaints raised by people using the pharmacy services.

The pharmacy had up-to-date indemnity insurance. The pharmacy kept the Responsible Pharmacist (RP) records electronically. A sample showed the entries were not always in chronological order and several entries didn't have the time the pharmacist ceased to be the RP. A sample of controlled drugs registers showed they were completed correctly but checks of the balance in each register had not been done for several months. And some balances were wrong. The team members correctly managed people's confidential information and they separated confidential waste for shredding offsite.

The pharmacist had completed level 2 training from the Centre for Pharmacy Postgraduate Education (CPPE) on protecting children and vulnerable adults. The team had some knowledge on safeguarding concerns but the pharmacy didn't have any safeguarding procedures and guidance for the team to follow.

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

Summary findings

The pharmacy has a small team who mostly have the qualifications and skills to provide the pharmacy's services. But not all team members have a recognised training qualification for their role. And they are not completing a training course as required. Team members work well together and support each other in their day-to-day work. But they don't have many opportunities to undertake additional training or get feedback on their performance. So, they may miss opportunities to develop their knowledge and skills.

Inspector's evidence

A full-time locum pharmacist covered the opening hours whilst the pharmacist manager was on a planned absence. The pharmacy team consisted of two full-time dispensers and a part-time medicines counter assistant (MCA). The MCA labelled prescriptions and dispensed medicines into the multi-compartment compliance packs but was not enrolled onto the appropriate dispenser training course. The pharmacy also employed a qualified nurse to provide the NHS COVID-19 vaccination service.

The pharmacy team reported facing some staffing challenges in the last few months as its workload grew significantly. Some team members were not experienced as others with tasks such as ordering of stock. This meant when planned absences occurred these tasks were often not fully completed or done at all. The full-time dispenser with many years of experience was mostly responsible for the key tasks and had identified other team members need for training. This dispenser with support from the pharmacist had provided some training to the team. And reported that the team had worked well during the dispenser's planned absence to ensure tasks were completed.

The pharmacy didn't provide team members with additional training to help them continue to develop their knowledge and skills. And they received little feedback on their performance, which provided little opportunity to discuss their development needs.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean, secure and generally suitable for the services provided. And it has adequate arrangements for people to have private conversations with the team.

Inspector's evidence

The pharmacy premises were small, particularly the main dispensary which had very limited space for the team to work and store medicines. The dispensing benches were cluttered with baskets piled on top of each other, creating an increased risk of errors. And some baskets were stored on the floor in the dispensary. The team used a larger room downstairs to dispense the medication into the multi-compartment compliance packs and store the completed packs. The pharmacy had a small consultation room that was arranged to support the delivery of the COVID-19 vaccination service. The pharmacy provided some people with supervised doses of their medicines and they were offered the consultation room to take their doses in private. The team arranged for most people who wished to use the room to have their doses at times when the vaccination service wasn’t taking place. The pharmacy was hygienic with separate sinks for the preparation of medicines and hand washing. The pharmacy had restricted public access to the dispensary.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy adequately manages its services to help people receive appropriate care. It gets its medicines from reputable sources, and it mostly stores them appropriately. Team members carry out some checks to make sure medicines are in good condition and appropriate to supply. But some of their processes are not robust, introducing a risk of supplying out-of-date medicines. They generally provide people with suitable information about their medicines. However, they don't fully follow national guidance when supplying some higher-risk medicines.

Inspector's evidence

People accessed the pharmacy via a small step. The pharmacy kept a small range of healthcare information leaflets and the team provided people with information on how to access other healthcare services when required. The computer on the pharmacy counter had access to the pharmacy's electronic patient medication records (PMR). So, when a person presented the team member could check what stage the dispensing of their prescription was at. The pharmacy provided the NHS COVID-19 vaccination service and employed a full-time qualified nurse as the main vaccinator. The pharmacy had up-to-date patient group directions (PGDs) which gave the legal authority for the vaccines to be administered. The team providing the service also had up-to-date NHS information and guidance. The pharmacist had experience of the service and supported the nurse such as answering clinical queries. And providing advice to people presenting for the vaccine who were not eligible to receive it.

The pharmacy supplied medicine to some people daily as supervised and unsupervised doses. The doses were prepared in advance of supply to reduce the workload pressure of dispensing at the time of supply. The team provided people with clear advice on how to use their medicines. The team members were aware of the criteria of the valproate Pregnancy Prevention Programme (PPP) and the information to be provided to people. But dispensed packs of valproate were found with the dispensing label attached to the patient card embedded in the manufacturer's packaging. This meant it was not freely available to supply to the person.

The pharmacy provided multi-compartment compliance packs to help around 42 people take their medicines. To manage the workload the team divided the preparation of the packs across the month. The pharmacist had developed a template for the team to record the person's current medication, the dose times and when the packs were due to be supplied. However not all the team members were using this which led to two systems being used and ran the risk of the team not following up-to-date information. The team usually ordered prescriptions one week before supply to allow time to deal with issues such as missing items. The team members did not record the descriptions of the products within the packs. This meant people would not have all the information available to identify the medicines in the packs. They supplied the manufacturer's packaging leaflets with the packs. The pharmacy occasionally received copies of hospital discharge summaries via the NHS discharge medicines service.

The pharmacy had limited space for the team to have separate areas for labelling, dispensing and checking of prescriptions. This somewhat increased the risk of mistakes. Team members used baskets during the dispensing process to isolate individual people's medicines and to help prevent them becoming mixed up. The pharmacy had checked by and dispensed by boxes on dispensing labels to record who in the team had dispensed and checked the prescription. A sample found that the team

completed the boxes. The pharmacy used fridge stickers on bags and prescriptions to remind the team when handing over medication to include these items. The pharmacy kept a record of the delivery of medicines to people.

The pharmacy ordered and obtained most of its medicines from the company's head office. The team followed a detailed process to order the medication. This included a request from the head office team to take a photograph of the prescription showing the medicine prescribed when it wasn't a regularly supplied medicine. The photograph of the prescription submitted by the team didn't include any confidential information about the person the medication was prescribed for. The team members received limited information from the head office team about delays with the supply of medication ordered. They were often only aware when the delivery of medicines arrived and items were missing. This meant the team members had to spend time on the telephone establishing when the medicines would be available. So, they could share this information with the person prescribed the medication.

The team occasionally checked the expiry dates on stock but didn't keep a record of this. The team members didn't mark medicines with a short expiry date to prompt them to check the medicine was still in date. A sample of medicines found three products that were out of date that had not been marked. The pharmacist looked at the expiry date of the medicines as part of their check of the dispensed item. A few bottles containing tablets removed from the original pack were found without a batch number or expiry date on the label. This meant the team could not action any safety alert for the medicine. And did not know whether the medication was in date. The team members recorded the dates of opening for medicines with altered shelf-lives after opening so they could assess if the medicines were still safe to use. The team checked and recorded fridge temperatures each day and a sample of these records found they were within the correct range. The pharmacy stored CDs in cabinets that met legal requirements. It had medicinal waste bins to store out-of-date stock and patient returned medication and the team used appropriate denaturing kits to destroy CDs. The pharmacy received alerts about medicines and medical devices from the Medicines and Healthcare products Regulatory Agency (MHRA) via email. The team usually printed off the alert, actioned it and kept a record.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide its services safely. It makes sure it uses its equipment appropriately to protect people's confidential information.

Inspector's evidence

The pharmacy had reference sources and access to the internet to provide the team with up-to-date clinical information. It had equipment available for the services provided including a range of CE equipment to accurately measure liquid medication. And it had a large fridge to store medicines kept at these temperatures. The fridge had a glass door that enabled the team to view stock without prolong opening of the door. The computers were password protected and access to people's records was restricted by the NHS smart card system. The pharmacy positioned the computer on the pharmacy counter in a way to prevent disclosure of confidential information. It stored completed prescriptions away from public view and it held private information in the dispensary and rear areas which had restricted public access.

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.