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: 30/08/2023

Pharmacy context

This community pharmacy is in the town of Knottingley. Its main activities are dispensing NHS prescriptions and selling over-the-counter medicines. It provides other NHS services including the Community Pharmacist Consultation Service and Hypertension case finding service.

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 suitably identifies and manages the risks associated with its services. It has written procedures that the pharmacy team generally follows and it completes the records it needs to by law. Team members protect people's private information correctly and they understand their roles in safeguarding the safety and wellbeing of children and vulnerable adults. They respond suitably to errors by discussing what happened and taking appropriate action to prevent future mistakes.

Inspector's evidence

The pharmacy had a range of standard operating procedures (SOPs). These provided the team with information to perform tasks supporting the delivery of its services. The process for dispensing medicines into multi-compartment compliance packs had changed and a SOP had been developed for this. Some SOPs had review dates due earlier in the year such as February 2023 but this had not happened. The team had read the SOPs but they hadn't signed the signature sheets to show they understood and would follow them. They demonstrated a clear understanding of their roles and referred queries from people to the pharmacist when necessary.

The pharmacy had a procedure 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 pharmacist discussed the error with the team member involved and completed the record on behalf of the team member. A sample of records showed details such as reflections on why the error occurred along with actions taken to prevent similar errors from happening again. For example, separating medicines that looked and sounded alike. Dispensing incidents were recorded and shared with the team. Errors that occurred with medicines supplied in multi-compartment compliance packs prepared at the company's offsite dispensary were reported back to the offsite dispensary team. The pharmacist reported that most of these errors related to medicines moving between different time slots. The pharmacy had a procedure for handling complaints raised by people using the pharmacy services. And received regular feedback from people on how its services were delivered. This included comments on how efficient the team was in dispensing people's prescriptions.

The pharmacy had current indemnity insurance A sample of records required by law such as the responsible pharmacist (RP) records and controlled drug (CD) registers met legal requirements. The correct RP notice was displayed. Appropriate records were kept of the supplies of unlicensed medicines. However, the records of CDs returned by people for destruction did not always capture when the CDs had been destroyed. 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. The delivery driver reported concerns back to the team who took appropriate action such as contacting the person's GP.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has a small team with an appropriate range of skills and experience to support its services. Team members work well together and support each other in their day-to-day work. They report concerns to help ensure the safe and effective delivery of pharmacy services. However, they have limited opportunities to complete ongoing training and reflect on their personal development. So, they may miss the chance to further their skills and knowledge.

Inspector's evidence

The pharmacist manager covered most of the opening hours with regular locum pharmacist cover. The pharmacy team consisted of one full-time dispenser, a part-time dispenser, a part-time trainee dispenser and a part-time delivery driver. At the time of the inspection all team members were on duty. Team members worked very well together and supported each other particularly to ensure people who presented at the pharmacy counter were not kept waiting. They held team meetings as and when information had to be shared such as changes to procedures. And they liaised with the team at the company's offsite dispensary hub to raise concerns about medicines supplied from the hub, and to give feedback.

Team members had limited opportunities to undertake 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. The pharmacy had recently changed software provider for its patient medication records (PMR) system. The RP had previously worked with the new system and provided training for the team. A member of the head office team had attended the pharmacy to provide training before the team started using the company's offsite dispensing hub.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean, secure and adequately sized for the services it provides. It has appropriate facilities to meet the needs of people requiring privacy when using the pharmacy services.

Inspector's evidence

The pharmacy premises were small, particularly the main dispensary which had limited space for the team to work and store medicines. Team members managed this adequately but some baskets containing dispensed medicines were piled on top of each other, creating an increased risk of errors. And some baskets were stored on the floor in the dispensary. However, there were no options available to expand the dispensary within the confines of the retail unit that housed the premises. A larger room downstairs was used to dispense medication into the multi-compartment compliance packs and store the completed packs. And it was discussed whether this could be used to store medicines or other stock items to create more space in the main dispensary.

The pharmacy was hygienic with separate sinks for the preparation of medicines and hand washing. And hand sanitising gel was also available. An air-conditioning unit had recently been installed which helped the team maintain an appropriate temperature in the dispensary. Team members used a small consultation room for private conversations with people and when providing services such as the Hypertension case finding service. The pharmacy had restricted public access to the dispensary.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy generally manages its services well to help people receive appropriate care and to make sure they receive their medicines when they need them. It obtains its medicines from reputable sources and it stores them properly. The team carries out checks to make sure medicines are in good condition and appropriate to supply.

Inspector's evidence

People accessed the pharmacy via a small step and team members helped people who could not directly access the pharmacy. 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. Team members asked suitable questions when selling over-the-counter (OTC) medicines and they provided people with appropriate advice on how to take their medication. The computer on the pharmacy counter had access to the pharmacy's PMR. So, when a person presented the team member could check what stage the dispensing of their prescription was at.

The pharmacy supplied medicine to several 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 and stored securely. Team members provided people with clear advice on how to use their medicines. They were aware of the criteria of the valproate Pregnancy Prevention Programme (PPP) and the information to be provided to people. The RP reported that no-one currently prescribed valproate met the PPP criteria.

The pharmacy provided multi-compartment compliance packs to help several people take their medicines. Most of the packs were dispensed at the pharmacy's offsite dispensary hub. Packs supplied to people on a weekly basis were dispensed at the pharmacy. The team usually ordered prescriptions two weeks before supply to allow time to deal with issues such as missing items. Prescriptions were labelled at the pharmacy and clinically checked by the pharmacist before they were sent to the hub for dispensing. Descriptions of the products within the packs were not recorded but the manufacturer's packaging leaflets were supplied. This meant people would not have all the information available to identify the medicines in the packs. Completed packs were stored in baskets labelled with the person's name and address. And packs supplied from the hub were labelled to inform the person they had been dispensed offsite.

The pharmacy had limited space for team members to create separate areas for the labelling and dispensing of prescriptions. They managed this by using 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 RP signed the checked box but the team did not sign the dispensed box. The labels on the multi-compartment compliance packs dispensed at the offsite dispensing hub did not have any of the boxes completed. The RP had highlighted this to the team at the hub. 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. A bag label embedded with a unique bar code was generated and scanned by the team when placing the dispensed medication in the collection area and the delivery section.

The pharmacy ordered 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 promptly received information from the head office team about delays with the supply of medication ordered.

The team checked the expiry dates on stock but didn't keep a record of this. They marked medicines with a short expiry date to prompt them to check the medicine was still in date. No out-of-date medicines were found. 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 were within the correct range. They also used a data logger placed in the fridge to keep detailed records of the fridge temperatures throughout the day. The logger sounded an alarm when the temperature went out of range. The pharmacy stored CDs in cabinets that met legal requirements. It had medicinal waste bins to store out-of-date stock and 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 which were appropriately actioned.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide its services safely. And it makes sure its equipment is used 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 information. It had equipment available for the services provided including cylinders to accurately measure liquid medication. And it had a large fridge to store medicines kept at these temperatures. 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. Team members used cordless telephones to help ensure their conversations with people were held in private.

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.