General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Allerton Pharmacy, Bell Dean Road, Allerton, BRADFORD, West Yorkshire, BD15 7WA

Pharmacy reference: 1089115

Type of pharmacy: Community

Date of inspection: 18/07/2019

Pharmacy context

The pharmacy is adjacent to a health centre in a residential suburb of Bradford. Pharmacy team members mainly dispense NHS prescriptions and sell a range of over-the-counter medicines. They offer services including medicines use reviews (MUR) and the NHS New Medicines Service (NMS). And, they provide a substance misuse service, including supervised consumption. They provide multi-compartmental compliance packs to help people take their medicines.

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	Pharmacy team members do not keep accurate records of balances of controlled drugs. They do not check the stock balances regularly. And, they do not act to quickly resolve any discrepancies they find. There may be a risk the team members do not identify any errors in dispensing in a timely manner.
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 not all met**

Summary findings

The pharmacy has up-to-date procedures to manage the risks in the pharmacy. And it keeps most of the records it must by law. But it doesn't keep accurate records of some of its higher risk medicines. The pharmacy team members don't check the stock balances of these medicines regularly. And they don't resolve any stock balance errors they identify promptly. The pharmacy team members record mistakes they make during dispensing. And they discuss these mistakes and make changes to prevent similar mistakes from happening again. They understand their responsibilities in protecting people's private information and they keep this information safe. The pharmacy team members know how to help protect the welfare of children and vulnerable adults.

Inspector's evidence

The pharmacy had a set of standard operating procedures (SOPs) in place to help manage the risks to its services. The sample checked were last reviewed in 2018. And the next review was scheduled for 2020. But there was no version control information displayed on each procedure. Pharmacy team members had read and signed the SOPs after the last review in 2018. The pharmacy defined the roles of the pharmacy team members in each procedure.

The pharmacist highlighted and recorded near miss errors made by the pharmacy team when dispensing. Pharmacy team members discussed the errors made. And, they talked about why a mistake had happened to help inform the changes they made. But, they did not record any information about why a mistake had happened. The pharmacist analysed the data collected about mistakes every six months. But, their analysis was based on quantitative information, such the number of different types of errors occurring, for example wrong strength and wrong form. They did not analyse the data for patterns of causes. The pharmacy had a clear process for dealing with dispensing errors that had been given out to people. It recorded incidents on a template reporting form. The sample of records seen were comprehensive and discussed what had happened, why and the changes proposed to prevent recurrence. Pharmacy team members made changes after mistakes to prevent them happening again. One example of change they had made was highlighting shelves in front of look-alike and sound-alike medicines that had been involved in a mistake to highlight the risk when dispensing.

The pharmacy had a procedure to deal with complaints handling and reporting. But, it did not advertise the procedure to people using the pharmacy. It collected feedback from people by using questionnaires and also verbally. One example of a change made after feedback was changing the layout of the retail area. Chairs for people waiting were moved away from the counter. And, gondolas containing stock were moved to provide more space.

The pharmacy kept controlled drug (CD) registers complete. It kept running balances in all registers. But, these were not audited against the physical stock quantity frequently, including methadone. For example, pharmacy team members last audited the registers for Medikinet XL 30mg capsules and Morphine 10mg tablets in January 2019. The inspector found discrepancies between the register quantity and the actual stock holding for five different CDs. The pharmacist said she was aware of the discrepancies. And, they had come to her attention after conducting a balance check in April and May 2019. Pharmacy team members had continued to make entries in the registers since. And, they had maintained an incorrect running balance. Both pharmacists present admitted that the issues remained

unresolved because they had not found the time to deal with them. And, because they felt unsure about how to resolve them. By not prioritising the resolution of the known CD discrepancies, there was a risk the team didn't know if there had been a dispensing error with any of these medicines. This was discussed and both pharmacists gave an assurance that all discrepancies found would be investigated urgently. The pharmacy had up to date professional indemnity insurance in place. It kept and maintained a register of CDs returned by people for destruction. And it was complete and up to date. The pharmacy maintained a responsible pharmacist record on paper. And it was complete and up to date. The pharmacist displayed their responsible pharmacist notice to people using the pharmacy. Pharmacy team members monitored and recorded fridge temperatures daily in two fridges. They kept private prescription records in a paper register, which was complete and in order. And, they recorded emergency supplies of medicines in the private prescription register. They recorded any unlicensed medicines supplied, which included the necessary information in the samples seen.

The pharmacy kept sensitive information and materials in restricted areas. And, it collected confidential waste in dedicated bags. The bags were sealed when they were full. And they were collected and sent for destruction at one of the company's other pharmacies. Pharmacy team members had been trained to protect privacy and confidentiality. The pharmacist had delivered the training verbally. Pharmacy team members were clear about how important it was to protect confidentiality. And there was a procedure in place detailing requirements under the General Data Protection Regulations (GDPR Confidentiality code of conduct signed in 2018. Pharmacy team members signed confidentiality agreements with the pharmacy every two years.

When asked about safeguarding, a dispenser gave some brief examples of symptoms that would raise their concerns in both children and vulnerable adults. But, they were generally unsure. They explained how they would refer to the pharmacist. The pharmacist said they would assess the concern. And would refer to the person's GP or local safeguarding teams for advice. The pharmacy had contact details available for the local safeguarding service. The dispenser was unsure when they had last completed training about safeguarding. But, they said it was not recently. The pharmacist had completed distance learning in 2018. The pharmacy did not have a documented procedure to instruct staff about what to do in the event of a concern. This was discussed with the pharmacist and they gave an assurance that a procedure would be put in place as soon as possible.

Principle 2 - Staffing ✔ Standards met

Summary findings

Pharmacy team members have the right skills and qualifications for their roles and the services they provide. They complete training ad-hoc. And, they discuss any learning needs with their manager. Pharmacy team members talk together openly to manage the workload and improve ways of working. And they have group discussions about why mistakes happen, so they can make changes to help prevent mistakes happening again.

Inspector's evidence

At the time of the inspection, the pharmacy team members present were two pharmacists, two dispensers, one apprentice dispenser and a medicines counter assistant. Pharmacy team members completed training ad-hoc by reading various trade press materials. And by having regular discussions with the pharmacists about current topics. The pharmacy did not have an appraisal or performance review process. A dispenser said that any needs she had would be discussed with the pharmacist informally and they would support her to achieve her goals. The pharmacist said there were plans to introduce an appraisal process. And, she expected pharmacy team members would be asked to set objectives to address any needs they had.

A pharmacy team member explained she would raise professional concerns with the pharmacist, superintendent pharmacist (SI) or pharmacy owners. She said she felt comfortable raising a concern. And confident that her concerns would be considered, and changes would be made where they were needed. The pharmacy did not have a whistleblowing policy. A dispenser said she would raise an anonymous concern with the GPhC. Pharmacy team members openly discussed tasks, issues and any mistakes they made. The dispenser said she was told by the pharmacist when she had made a mistake. The discussion that followed also explored why she had made the mistake. And, she said she would always try and change something to prevent the mistake happening again with help from her colleagues. The pharmacy owners and SI asked the team to achieve as many prescription items as possible each month. Pharmacy team members were not asked to reach any other targets.

Principle 3 - Premises ✔ Standards met

Summary findings

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

Inspector's evidence

The pharmacy was clean and well maintained. All areas of the pharmacy were tidy and well organised. And the floors and passage ways were free from clutter and obstruction. There was a safe and effective workflow in operation. And clearly defined dispensing and checking areas. It kept equipment and stock on shelves throughout the premises. The pharmacy had a private consultation room available. The pharmacy team used the room to have private conversations with people. The room was signposted by a sign on the door.

There was a clean, well maintained sink in the dispensary used for medicines preparation. There was a toilet, which had a sink with hot and cold running water and other facilities for hand washing. Heat and light in the pharmacy was maintained to acceptable levels. The overall appearance of the premises was professional, including the exterior which portrayed a professional healthcare setting. The professional areas of the premises were well defined by the layout and well signposted from the retail area.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy is accessible to people. And it generally provides its services safely and effectively. It stores, sources and manages its medicines safely. The pharmacy team members dispense medicines into devices to help people remember to take them correctly. They provide information with these devices to help people know when to take their medicines. And to identify what they look like. The team takes steps to identify people taking high-risk medicines. And it provides them with some advice to help people take these medicines safely.

Inspector's evidence

The pharmacy had level access from the street. But there was no bell or sign for people to use to get staff attention if they needed help getting in to the pharmacy. The medicines counter assistant (MCA) said she would use written communication with someone with hearing impairment if necessary. And, she gave an example of someone who came to the pharmacy with his own pad and pen, often with the details of what he needed already written down. She explained that she would ask people how best to help them if they had difficulty communicating or were having difficulty using or taking their medicines. Other pharmacy team members explained they could provide large print labels to people with visual impairment.

The MCA gave a sound explanation of how she would establish if a medicine was safe and appropriate to supply to someone requesting to buy medicines over the counter. She clearly explained the questions she would ask. And, she gave examples of medicines where she would restrict the quantity supplied, either to help keep people safe or to comply with the law, for example products containing paracetamol, codeine or pseudoephedrine. She also highlighted products where she would refer requests for the immediately to the pharmacist, for example Viagra Connect.

Pharmacy team members signed the dispensed by and checked by boxes on dispensing labels. This was to maintain an audit trail of staff involved in the dispensing process. The pharmacy team used dispensing baskets throughout the dispensing process to help prevent prescriptions being mixed up. The pharmacy supplied medicines in multi-compartmental compliance packs when requested. The pharmacy attached backing sheets to the pack, so people had written instructions of how to take the medicines. And these backing sheets included the descriptions of what some of the medicines looked like, so they could be identified in the pack. Pharmacy team members provided people with patient information leaflets about their medicines each month. And, they documented any changes to medicines provided in packs on the patient's electronic medication record. The pharmacist explained she would provide counselling and information to people prescribed valproate that could become pregnant. She said she would check that they were enrolled on a pregnancy prevention programme. But the pharmacy did not have any printed information to give to people to fully explain the risks. The pharmacist said she would order a stock of information material as soon as possible.

Pharmacy team members checked medicine expiry dates every 12 weeks. But, they did not keep any records of date checking. They highlighted any short-dated items with a sticker on the pack up to six months in advance of its expiry. And, pharmacy team members checked stock every week to look for stickers and remove expiring medicines. The inspector checked a sample of stock and no out-of-date medicines were found. And, several items were found marked as short dated as described. Pharmacy

team members implemented drug alerts and recalls when they were received. And, any affected stock found was quarantined for destruction or return to the wholesaler. They recorded any action taken. And, records included details of any affected products removed. The pharmacy obtained medicines from three licensed wholesalers. It stored medicines tidily on shelves and in drawers. And all stock was kept in restricted areas of the premises where necessary. It had disposal facilities available for unwanted medicines, including controlled drugs (CDs). Pharmacy team members kept the CD cabinet tidy and well organised. And, out-of-date and patient-returned CDs were segregated. The pharmacy team kept the contents of the pharmacy fridge tidy and well organised. They monitored minimum and maximum temperatures in the fridge every day. And they recorded their findings. The temperature records seen were within acceptable limits. Pharmacy team members were aware of the requirements of the Falsified Medicines Directive. The pharmacy had installed new scanners in preparation for scanning compliant packs of medicines. But, no software was in place and procedures had not been changed. And pharmacy team members had not been trained about how to incorporate the requirements in to the dispensing process. So, the pharmacy was not complying with current law.

The pharmacy delivered medicines to people. It recorded the deliveries made and asked people to sign for their deliveries. The delivery driver left a card through the letterbox if someone was not at home when they delivered. The card asked people to contact the pharmacy to arrange a re-delivery. The team highlighted bags containing CDs with a sticker on the bag and on the driver's delivery sheet.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the necessary equipment available for the services it provides, which it keeps properly maintained. It manages and uses the equipment in ways that protect confidentiality.

Inspector's evidence

The pharmacy had the equipment it needed to provide the services offered. The resources available included the British National Formulary (BNF), the BNF for Children, various pharmacy reference texts and use of the internet. Pharmacy team members obtained equipment from the licensed wholesalers used. And they had a set of clean, well maintained measures available for medicines preparation. They used a separate set of measures to dispense methadone. The pharmacy positioned computer terminals away from public view. And these were password protected. It stored medicines waiting to be collected in the dispensary, also away from public view. The pharmacy had a medicines fridge that was in good working order. And, pharmacy team members used it to store medicines only. They restricted access to all equipment and they stored all items securely.

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.