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: 07/09/2020

Pharmacy context

The pharmacy is next to a health centre in a residential suburb of Bradford. Pharmacy team members dispense NHS prescriptions and sell a range of over-the-counter medicines. They offer services such as the NHS New Medicine Service (NMS). And they provide a substance misuse service, including supervised consumption. The pharmacy provides medicines to people in multi-compartment compliance packs to help them take their medicines safely. And it delivers 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 has appropriate procedures in place to help manage the risks in the pharmacy. It keeps adequate records of the things it must do by law. Pharmacy team members generally record the mistakes they make during dispensing. They discuss these mistakes and make suitable changes to prevent similar mistakes from happening again. They understand their responsibilities in protecting people's private information and they keep this information safe. Pharmacy team members know how to help protect the welfare of children and vulnerable adults. But the pharmacy could do more to help effectively manage the risks associated with the coronavirus pandemic.

Inspector's evidence

The pharmacy had not documented a risk assessment to help them manage the risks of the coronavirus pandemic. It had installed a screen at the counter to help protect pharmacy team members and the public. And pharmacy team members were restricting access to the pharmacy to two people at a time. Pharmacy team members had access to personal protective equipment (PPE) such as masks, gloves and face visors. The pharmacist said team members had been wearing PPE all the time at the height of the pandemic. But as lockdown had been eased, pharmacy team members were given the choice about whether to wear PPE while working. Pharmacy team members were able to maintain appropriate social distancing while they worked. But this was not always possible. And pharmacy team members, who weren't wearing PPE, were seen on occasions coming closer than one metre to each other and to people using the pharmacy. This was discussed with the pharmacist. She agreed that the pharmacy could do more to help prevent the spread of the virus. And to prevent all pharmacy team members being asked to isolate if the pharmacy was contacted by NHS Test and Trace. She also gave an assurance that a documented risk assessment would be completed immediately.

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. The review had been delayed because of the coronavirus pandemic. 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 pharmacy team members 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 much information about why a mistake had happened. The pharmacist analysed the data collected about mistakes every three to four months. But her analysis was based on quantitative information, such the number of different types of errors occurring, for example wrong strength and wrong form. She did not analyse the data for patterns of causes. And she did not record her analysis. The pharmacist said that during the coronavirus pandemic, some mistakes had been made that had not been recorded. And this was reflected in the records where there were significantly fewer records for April, May and June 2020. She explained that each error had been discussed, and changes had been made where necessary to help prevent them happening again. 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 and the changes proposed to prevent

recurrence. And some discussed why the mistakes had happened in detail, but not all. Pharmacy team members made changes after their mistakes to help 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 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 had up-to-date professional indemnity insurance in place. The pharmacy kept controlled drug (CD) registers complete and in order. It kept running balances in all registers. And these were audited against the physical stock quantity after each entry was made in the register. The pharmacy kept and maintained a register of CDs returned by people for destruction. And it was complete and up to date. It maintained a responsible pharmacist record electronically. And it was complete and up to date. The pharmacist displayed their responsible pharmacist notice to people. 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. Pharmacy team members signed confidentiality agreements with the pharmacy every two years.

When asked about safeguarding, a dispenser gave some brief examples of signs 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.

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 informally as they come across things. And they discuss any learning needs with their manager. Pharmacy team members talk together openly to manage the workload and improve ways of working. 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 the superintendent pharmacist (SI), one dispenser, two medicines counter assistants and a work experience student. 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 that she would raise professional concerns with the SI or pharmacy owner. 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. The pharmacy has made some sensible adjustments to its premises to help prevent the spread of coronavirus.

Inspector's evidence

The pharmacy was clean and well maintained. Pharmacy team members kept all areas of the pharmacy tidy and well organised. And they kept the floors and passageways free from clutter and obstruction. The pharmacy had 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. Pharmacy team members used the room to have private conversations with people. They signposted people to the room verbally. And there was a sign on the door. The pharmacy had installed a screen at the counter to help protect pharmacy team members and the public against the spread of coronavirus. And pharmacy team members were restricting access to the pharmacy to two people at a time to help maintain proper social distancing.

The pharmacy had a clean, well maintained sink in the dispensary, which pharmacy team members used for medicines preparation and to wash their hands. The pharmacy had a toilet, which had a sink with hot and cold running water and other facilities for hand washing. The pharmacy maintained heat and light to acceptable levels. The overall appearance of the premises was professional, including the exterior which portrayed a professional healthcare setting.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy is easily accessible to people. It provides its services safely and effectively. And it generally stores, sources and manages its medicines safely. Pharmacy team members dispense medicines into devices to help people remember to take them correctly. They provide appropriate information with these devices to help people know when to take their medicines. And to identify what they look like. The team identifies people taking high-risk medicines. And it provides them with some suitable 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 into the pharmacy. Pharmacy team members said they would use written communication with someone with hearing impairment if necessary. They explained they would ask people how best to help them if they had difficulty communicating or were having difficulty using or taking their medicines. The pharmacy could provide large print labels to help people with visual impairment.

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. They used dispensing baskets throughout the dispensing process to help prevent prescriptions being mixed up. The pharmacy supplied medicines to people in multi-compartment compliance packs when requested. The pharmacy attached backing sheets to the packs, so people had written instructions of how to take the medicines. And these backing sheets included descriptions of what 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 advice and information to people who could become pregnant that were prescribed valproate. 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 issue of lack of printed material was also raised at the pharmacy's last inspection. 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. And they recorded these checks. 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. The inspector found several amber bottles on the shelves that contained medicines that had been removed from their original packaging by mistake during the preparation of multi compartment compliance packs. Pharmacy team members had labelled the bottles with the name and strength of the medicines. But they had not included the medicine's batch number and expiry date. So, pharmacy team members would not know if the medicine was out of date. Or whether the medicine had been recalled. Pharmacy team members implemented drug alerts and recalls when they were received. And they quarantined any affected stock found for destruction or return to the wholesaler. They recorded any actions they took. And their records included details of any affected products removed. The pharmacy obtained medicines from licensed wholesalers. It stored its medicines tidily on shelves and in drawers.

And it kept all stock 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 they segregated any out-of-date and patient-returned CDs. The inspector checked the physical stock against the register running balance for one product. And it was correct. Pharmacy team members kept the contents of the pharmacy fridges tidy and well organised. They monitored minimum and maximum temperatures in the fridges 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 it did not have any software in place and the pharmacy's documented procedures had not been changed.

The pharmacy delivered medicines to people. And it recorded the deliveries it made. 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. Pharmacy team members highlighted bags containing CDs with a sticker on the bag and on the driver's delivery sheet. Pharmacy team members explained that deliveries had increased significantly during the coronavirus pandemic. They said deliveries were still in high demand. And they had started to ask people who were not shielding to collect their medicines if possible, to help them manage their workload more effectively. And to be able to prioritise deliveries to the most vulnerable people.

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. The pharmacy had a set of clean, well maintained measures available for medicines preparation. It had 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 two medicines fridges that were in good working order. And pharmacy team members used them 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.