General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Birkenshaw Pharmacy, Town Street Medical Centre, Town Street, Birkenshaw, BRADFORD, West Yorkshire, BD11 2HX

Pharmacy reference: 1089323

Type of pharmacy: Community

Date of inspection: 05/02/2024

Pharmacy context

The pharmacy is adjacent to a GP surgery in Birkenshaw, near Bradford. 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 and emergency hormonal contraception. 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 most of 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. Team members record and discuss the mistakes they make so that they can learn from them. But they don't always follow documented procedures to help capture key information or analyse these records, 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 the risks. These were available to team members electronically. The superintendent pharmacist (SI) had reviewed the SOPs in 2022. And they were due to review them again in 2024. Pharmacy team members had signed a paper record to confirm their understanding of some of the SOPs since they had been reviewed. But they had not read or signed all of them. This meant they might not always fully understand their responsibilities.

The pharmacy had recently started to provide 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. But the responsible pharmacist (RP) confirmed that these assessments had not been written down to help them manage emerging risks on an ongoing basis as the service developed. Pharmacy team members had created a poster which they displayed in various places behind the pharmacy's retail counter. The poster highlighted the key inclusion criteria for each condition covered by the service. Team members used the poster as an aide memoire to help them appropriately refer people to the pharmacist for a consultation. The RP demonstrated how they recorded their consultations, including capturing consent to share information with the person's GP. And they recorded the information provided to people so that they knew how to use their medicines effectively, and what to do if their symptoms did not resolve.

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 team members do this effectively. Team members discussed their errors and why they might have happened. And they used this information to make some changes to help prevent the same or similar mistakes from happening again. For example, team members described how they highlighted prescriptions for unusual forms of medicines, such as rosuvastatin capsules, to help prevent the incorrect form being dispensed. Pharmacy team members did not always capture detailed 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. But team members did not regularly analyse their errors for patterns, so they might miss opportunities to reflect, learn, and make improvements to the pharmacy's services. Pharmacy team members gave a clear explanation of how they would handle and record a dispensing error. But this did not match the

documented procedure in place. A pharmacy team member showed a recent record they had made, which provided comprehensive information about the incident and how it was resolved. They made records of errors on the person’s electronic patient medication record (PMR). But this relied on people remembering the person’s name if they needed to revisit the record later, which made future reflection and learning difficult.

The pharmacy had a documented procedure for handling complaints and feedback from people. Pharmacy team members explained people usually provided verbal feedback. And any complaints were referred to the pharmacy manager or 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 up-to-date professional indemnity insurance in place. The pharmacy kept accurate controlled drug (CD) registers. It kept running balances for all registers. Pharmacy team members audited these balances each month, or each week for methadone. 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.

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 did not have a documented procedure for dealing with concerns about children and vulnerable adults. So, team members might not always be clear how to properly handle a concern. Pharmacy team members explained they had completed formal safeguarding training. But they could not remember when they had last trained, and there were no records in the pharmacy to confirm when their formal training had last been completed.

Principle 2 - Staffing ✔ Standards met

Summary findings

Pharmacy team members have the right qualifications and skills for their roles and the services they provide. And they discuss how to best use team members' skill to provide their services most effectively. Team members complete some ongoing ad hoc learning to help keep their knowledge and skills up to date. And they 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, a pharmacy technician who was also the pharmacy manager, and a qualified dispenser. The pharmacy technician was also qualified to perform the final accuracy check of a prescription. But they explained they were not currently using their checking skills because until recently, the pharmacy had been operating using different locum pharmacists. The pharmacist and technician also explained how the team were exploring ways to manage their workload at the same time as providing people with NHS Pharmacy First consultations. During consultations, the pharmacist was likely to be in the consultation room for longer periods. So, team members discussed ways to manage the pharmacy's other services. This included using the technician's checking skills as the service became busier.

Pharmacy team members completed training ad hoc by reading various materials. And by completing training modules provided by the NHS e-learning for healthcare platform when available. The pharmacy did not have a formal appraisal or performance review process for pharmacy team members. A team member explained they would raise any learning needs verbally with the pharmacist or the SI who worked at another pharmacy locally. And they were supported by being signposted to relevant reference sources or by discussion to help address their learning needs.

Pharmacy team members explained how they would raise professional concerns with the pharmacy manager, pharmacist, 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 did not have a formal whistleblowing policy. Pharmacy team members were aware of organisations outside the pharmacy where they could raise professional concerns, such as the NHS or GPhC. Pharmacy 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 the pharmacy's shelves to store their 150 most used medicines more effectively. They explained the changes had improved the safety and efficiency of their dispensing process. And had reduced the amount of stock being stored in the small stock room, reducing the health and safety risks to team members. The pharmacy owners did not ask pharmacy team members to meet any performance related targets.

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. Its 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. The pharmacy generally stores and manages its medicines appropriately. But pharmacy team members don't always follow the pharmacy's SOP for managing the expiry dates of medicines. So, there is a risk that people might receive medicines that have expired.

Inspector's evidence

The pharmacy had ramped access from the street. 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 and text messages to help people with hearing impairment access their services and use their medicines safely.

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. But the pharmacy had not recently completed any audits to establish whether advice had been provided to everyone who it provided with valproate. Pharmacy 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.

Pharmacy team members signed the 'dispensed by' and 'checked by' boxes on dispensing labels during dispensing. This was to maintain 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.

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

month. But they did not always record their checks. And the documented procedure for expiry date checking did not match the process being carried out. Pharmacy team members explained they would record expiring items on a monthly stock expiry sheet up to six months before their expiry. And these items would be removed from the shelves at the beginning of their month of expiry. They did not highlight the packs to alert team members the medicines were short dated when dispensing. This was discussed, and the pharmacy manager agreed to highlight packs of short dated medicine to help prevent them being dispensed inappropriately. 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 recall. But they did not record these actions.

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.