General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Tyersal Pharmacy, 6 Tyersal Road, Tyersal, BRADFORD, West Yorkshire, BD4 8ET

Pharmacy reference: 1090100

Type of pharmacy: Community

Date of inspection: 05/12/2019

Pharmacy context

This community pharmacy is in a small parade of shops in the Bradford suburb of Tyersal. The pharmacy dispenses NHS and private prescriptions. The pharmacy supplies multi-compartment compliance packs to help people take their medicines. And it delivers medication to people's homes. The pharmacy provides the seasonal flu vaccination service. And it provides the supervised methadone consumption 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 generally identifies and manages the risks associated with its services. And it keeps most of the records it needs to by law. The pharmacy has written procedures that the team follows. And some of the team members have signed to say they have read the procedures. The pharmacy team has some level of training, guidance and experience to respond to safeguarding concerns to protect the welfare of children and vulnerable adults. The pharmacy team members respond appropriately when errors happen. They discuss what happened and they act to prevent future mistakes. But they don't always record the actions they have taken to prevent errors or regularly review the errors. This means the team may miss opportunities to help identify patterns and reduce 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 services. The SOPs covered areas such as dispensing prescriptions and controlled drugs (CDs) management. Several SOPs did not have the date of preparation or a review date. The pharmacy pre-registration student had read the SOPs and signed the SOP signature sheet to confirm they had read and understood them. The rest of the team had read and signed the signature sheet for a few SOPs and were reading and signing the rest of the SOPs. The pharmacy had up-to-date indemnity insurance.

On most occasions the pharmacist when checking prescriptions and spotting an error asked the team member involved to find and correct the mistake. The pharmacy kept records of these near miss errors. A sample of the error records looked at found that the team sometimes recorded details of what had been prescribed and dispensed to spot patterns. But team members did not always record what caused the error. And none of the records looked at had details of what the team member had learnt from the error and the actions they had taken to prevent the mistake happening again. The pharmacy team recorded dispensing incidents. These were errors identified after the person had received their medicines. All team members were informed of the dispensing incident so they were aware of it and could learn from it. The dispensing incident report detailed the cause of the error and the actions taken by the team to prevent the error happening again. A sample of dispensing incident reports looked at found the causes included cluttered shelves leading to picking errors. And the pharmacist multitasking when checking multi-compartment compliance packs. The actions captured on the reports to prevent the same mistake included organising the medicines on the storage shelves and reducing clutter. And to introduce a triple check of multi-compartment compliance packs.

The pharmacy occasionally completed a monthly review of near miss errors and dispensing incidents to identify patterns. But most reviews were from 2018, none were done in 2019. The pharmacy completed an annual patient safety report. The 2019 report stated that new staff were better supervised, and this helped to reduce errors. And the team used different shelves for similar sounding medicines. The team had separated amlodipine and amitriptyline after identifying they were often involved with picking errors. The team also tried to get medicines from the wholesaler that had different packaging to help reduce picking errors. The 2019 report highlighted that the team was to check the medicines picked for the multi-compartment compliance packs before dispensing. So, team members could ensure they had picked the correct medicine before removing it from the packaging.

The pharmacy had a procedure for handling complaints raised by people using the pharmacy. But there was no information in the form of a leaflet or poster to provide people with details on how to raise a concern. The pharmacy team used surveys to find out what people thought about the pharmacy. The pharmacy published these on the NHS.uk website. The pharmacy received regular feedback from people using the pharmacy Facebook page. The pharmacy used the Facebook page to promote pharmacy services. And local community initiatives and funding raising. The team had received positive feedback from a parent after they stayed late to dispense a child's prescription.

A sample of controlled drugs (CD) registers looked at found that they did not meet all legal requirements. Several CD registers did not have the headers completed. The pharmacy did not regularly check the CD stock against the balance in the register to help spot errors such as missed entries. During the inspection a discrepancy was found with one of the CD registers. The pharmacists on duty investigated but could not locate the missing items. The pharmacy reported this to the NHS Accountable Officer. The pharmacy recorded CDs returned by people. And promptly destroyed them. A sample of Responsible Pharmacist records looked at found that they met legal requirements. Records of private prescription supplies, and emergency supply requests met legal requirements. A sample of records for the receipt and supply of unlicensed products looked at found that they met the requirements of the Medicines and Healthcare products Regulatory Agency (MHRA).

The team had received training on the General Data Protection Regulations (GDPR). The pharmacy had a privacy notice in line with the requirements of the GDPR. But it did not display the notice for people to see. The team separated confidential waste for shredding onsite. The pharmacy had safeguarding information for the team to refer to. And team members had access to contact numbers for local safeguarding teams. The pharmacists had completed level 2 training in 2019 from the Centre for Pharmacy Postgraduate Education (CPPE) on protecting children and vulnerable adults. The team had completed Dementia Friends training. The team responded well when safeguarding concerns arose. The dispenser had reported concerns about a person showing signs of dementia to the person's GP.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has a team with the qualifications and skills to support the pharmacy's services. The team members support each other in their day-to-day work. They identify improvements to the delivery of pharmacy services. And they update their processes, especially after dispensing errors happen, to improve their efficiency and safety in the way they work. The pharmacy gives team members feedback on their performance. So, they can take opportunities to develop and keep their skills up to date. But it doesn't provide its team members with regular ongoing training opportunities to support them to keep their knowledge up to date.

Inspector's evidence

The pharmacist owners and regular locum pharmacists covered the opening hours. The pharmacy team consisted of a full-time pharmacy pre-registration student, a full-time qualified dispenser, a full-time pharmacy apprentice, and a delivery driver. At the time of the inspection one of the regular locum pharmacists, one of the pharmacist owners, the pre-registration student, the qualified dispenser and the pharmacy apprentice were on duty. The pharmacy provided the pre-registration student and the pharmacy apprentice with protected training time. But it did not provide extra training to the team members once they were qualified. The pharmacy provided feedback for the team on their performance. So, they had a chance to reflect and discuss their development needs.

One of the pharmacist owners was the tutor for the pre-registration student. The student was given the role of managing the multi-compartment compliance packs service. The student liked this role especially the opportunities it gave for them to develop their clinical skills. For example, when reviewing hospital discharge summaries and contacting the person's GP to discuss the changes. The student had reviewed the processes for delivering the service. And had updated the process such as improving the record keeping.

The pharmacy team worked well together. The pharmacy held ad hoc team meetings usually at the end of the month. The team members could suggest changes to processes or systems such as rearranging the storage shelves to help them easily locate stock. The pharmacy did not set targets for services. The team offered the pharmacy services when they would benefit people.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean, secure and suitable for the services provided.

Inspector's evidence

The pharmacy was clean and hygienic. It had separate sinks for the preparation of medicines and hand washing. And it had alcohol gel for hand cleansing. The pharmacy had enough storage space for stock, assembled medicines and medical devices.

The pharmacy had a consultation room. The team used this for private conversations with people. The premises were secure. The pharmacy had restricted access to the dispensary during the opening hours. The window displays detailed the opening times and the services offered. The pharmacy had a defined professional area. And items for sale in this area were healthcare related.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides services that support people's health needs. The pharmacy has adequate procedures to manage its services. It keeps records of deliveries it makes to people's homes. So, it can deal with any queries effectively. But the team does not record descriptions of the medicines in the multi-compartment compliance packs or supply information leaflets with the medication supplied in these packs to help people take their medicines safely. The pharmacy gets its medicines from reputable sources. And it generally stores and manages medication appropriately. Team members don't always check and record fridge temperatures. So, there is a risk if the fridge stops working, they may supply medicines that are not fit for purpose.

Inspector's evidence

People accessed the pharmacy via a step free entrance. The team had access to the internet to direct people to other healthcare services. The pharmacy kept a range of healthcare information leaflets for people to read or take away. The pharmacy provided the flu vaccination service through patient group directions (PGDs). These provided the pharmacists with the legal authority to administer the vaccine. But the PGD for the NHS flu vaccination service was not available at the time of the inspection. Other paperwork for the NHS service was in place. The PGD for the private flu vaccination service had not been signed by the pharmacists authorised to administer the vaccine. The dispenser ran a local community initiative to raise money for groups such as Christmas gifts for children and collecting donations for a local food bank. A chiropodist regularly attended the pharmacy using the consultation room to provide the service. This helped several local people who could not access the service provided from other locations which were some distance from where they lived.

The pharmacy provided multi-compartment compliance packs to help around 61 people take their medicines. And to people living in two care homes. People received monthly or weekly supplies depending on their needs. The dispenser and the pharmacy pre-registration student managed the service. To manage the workload the team divided the preparation of the packs across the month. Each person had a record listing their current medication and dose times. The team checked received prescriptions against the list and queried any changes with the GP team. Some prescriptions were only sent on the day of supply. To manage this and reduce the risk of errors from preparing the packs on the day of supply the team dispensed and checked four weeks packs together against the first prescription. And stored these packs on dedicated shelves awaiting the prescription. The pharmacist completed a second check of the packs when the prescription arrived at the pharmacy. The pharmacy team ordered the prescriptions for the supplies to the care home. The care home team sent the pharmacy team the medicine administration charts for each person. The care home team used the charts to mark the medicines required for the next cycle. The team usually sent the supplies to the care home on the Thursday before the next cycle started on a Sunday. This gave the care home team time to check the supplies and chase up missing items. The team members did not record the descriptions of the products within the packs. And did not supply the manufacturer’s patient information leaflets. The team stored completed packs in box files labelled with the person’s name and address. The pharmacy received copies of hospital discharge summaries. The team checked the discharge summary for changes or new items. And sent a copy to the GP for reference and a request for prescriptions when required. The team stored weekly packs in baskets labelled with the person’s name and address.

The pharmacy supplied methadone as supervised and unsupervised doses. And it prepared the methadone doses in advance before supply. This reduced the workload pressure of dispensing at the time of supply. The pharmacy stored the prepared doses in the controlled drugs cabinet. But the CD cabinet was full of stock so there was no space to separate individual doses. The pharmacist used an elastic band to keep multiple doses for one person together. But the pharmacist did not use the prescription to wrap around the dose to help separate doses. And to ensure the pharmacist selected the correct one. The pharmacy used baskets to separate prescriptions for methadone doses collected and those due to be supplied.

The team members provided a repeat prescription ordering service. They used an electronic system to remind them when they had to request the prescription. And used this as an audit trail to track the requests. The team usually ordered the prescriptions a few days before supply. This gave time to chase up missing prescriptions, order stock and dispense the prescription. The team regularly checked the system to identify missing prescriptions and chase them up with the GP teams. The pharmacy team was aware of the criteria of the valproate Pregnancy Prevention Programme (PPP). The pharmacy had the PPP pack to provide people with information when required. And kept some of the PPP information leaflets and cards on the pharmacy counter for people to read and take away. Though the PPP cards were the old version.

The pharmacy provided separate areas for labelling, dispensing and checking of prescriptions. The pharmacy team used baskets when dispensing to hold stock, prescriptions and dispensing labels. This prevented the loss of items and stock for one prescription mixing with another. The team members referred to the prescription when selecting medication from the storage shelves. And they used this as a prompt to check what they had picked. The pharmacy used CD and fridge stickers on bags and prescriptions to remind the team when handing over medication to include these items. The pharmacy had a system to prompt the team to check that supplies of CD prescriptions were within the 28-day legal limit. The pharmacy had checked by and dispensed by boxes on dispensing labels. These recorded who in the team had dispensed and checked the prescription. A sample looked at found that the team sometimes only completed the checked by boxes. When the pharmacy didn't have enough stock of someone's medicine, it provided a printed slip detailing the owed item. And kept a separate one with the original prescription to refer to when dispensing and checking the remaining quantity. The pharmacy kept a record of the delivery of medicines to people. This included a signature from the person receiving the medication.

The pharmacy team checked the expiry dates on stock. And kept a record of this. The last date check was on 18 September 2019. The team highlighted medicines with a short expiry date. No out of date stock was found. The team members recorded the date of opening on liquids. This meant they could identify products with a short shelf life once opened. And check they were safe to supply. For example, an opened bottle of dexamethasone oral solution with three months use once opened had a date of opening of 03 August 2019 recorded. The pharmacy team checked the fridge temperatures and recorded the readings. But the pharmacy did not have any records for December 2019. And at the time of the inspection the fridge thermometer was not working. This was highlighted to the pharmacist owner present at the inspection to investigate and take action. The pharmacy had medicinal waste bins to store out-of-date stock and patient returned medication. And it stored out-of-date and patient returned controlled drugs (CDs) separate from in-date stock in a CD cabinet that met legal requirements. The team used appropriate denaturing kits to destroy CDs.

The pharmacy had no procedures or equipment to meet the requirements of the Falsified Medicines Directive (FMD). The pharmacist owner was waiting for the computer software supplier to upgrade the software. The pharmacy obtained medication from several reputable sources. And received alerts about medicines and medical devices from the Medicines and Healthcare products Regulatory Agency (MHRA)

via email. The team 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 safe services and it uses its facilities to protect people's private information.

Inspector's evidence

The pharmacy had references sources and access to the internet to provide the team with up-to-date clinical information. The pharmacy used a range of CE equipment to accurately measure liquid medication. And used separate, marked measures for methadone. The pharmacy had a fridge to store medicines kept at these temperatures.

The computers were password protected and access to people's records restricted by the NHS smart card system. The pharmacy positioned the dispensary computers in a way to prevent disclosure of confidential information. The pharmacy stored completed prescriptions away from public view. And it held private information in the dispensary and rear areas, which had restricted access. The team used cordless telephones to make sure telephone conversations 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.