General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Eggborough Pharmacy, 87 Selby Road, Eggborough, GOOLE, North Humberside, DN14 0LJ

Pharmacy reference: 1090750

Type of pharmacy: Community

Date of inspection: 13/06/2023

Pharmacy context

This community pharmacy is in the large village of Eggborough. Its main activities are dispensing NHS prescriptions and selling over-the-counter medicines. A few people receive their medicines in multi-compartment compliance packs to help them take their medication. The pharmacy also offers the NHS minor ailments service and the NHS Community Pharmacist Consultation Service. And it provides a delivery service to several people in the village and surrounding areas.

Overall inspection outcome

✔ **Standards met**

Required Action: None

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 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 mostly identifies and manages the risks associated with its services. It has written procedures that the pharmacy team largely follows. And it mostly 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 action to prevent future mistakes. But they do not regularly record all errors so they may miss opportunities to learn and improve the safety of services.

Inspector's evidence

The pharmacy had a range of up-to-date standard operating procedures (SOPs) that were kept electronically and as a paper version. These provided the team with information to perform tasks supporting the delivery of the pharmacy services. Team members had read the SOPs and signed the SOPs signature sheets to show they understood and would follow the SOPs. And they demonstrated a clear understanding of their roles and worked within the scope of their role.

The SOPs included details on how to record and learn from errors identified during the dispensing process, known as near misses. However, the near miss error records showed the last entry was made on 05 April 2023. A sample of records showed that the details captured enabled the team to identify patterns and take action to prevent the error from happening again. For example, one entry captured a learning point from the team member was to complete one task at a time. Team members shared common errors with each other along with their own learnings, so actions could be taken to prevent similar errors. This included separating medicines that looked and sounded alike such as amitriptyline and amlodipine. And marking the shelves holding these medicines to remind the team to double check the product selected. A procedure was in place for managing errors that were identified after the person received their medicines, known as dispensing incidents. But a recent dispensing incident had not been recorded as the team did not know how to do this following a change to the electronic patient medication record (PMR). All team members were aware of the dispensing incident and agreed to prevent similar errors by completing a second accuracy check of the dispensed medicine at the point of supply to the person. Team members were observed following this process.

The pharmacy had a procedure for handling complaints raised by people using the pharmacy services. Following concerns raised by people that their prescription was not ready to collect the team produced a poster that was displayed in the retail area. This advised people of the timescales from ordering a prescription to it being ready for collection. And plans were being made to set-up a text messaging service to inform people when their prescription was ready.

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 RP records were kept in a paper format, but the PMR also had a facility to keep RP records. This wasn't used by the RP, but the system captured the pharmacy technician's details when they signed in each day and added them into the RP record. This was highlighted to the team during the inspection to raise with the PMR provider. A sample of records of private prescription supplies showed some entries didn't detail the prescriber or had the wrong prescriber's details. A few entries were also missing the dates of supply. This was a matter raised at the inspection in 2019. Pharmacy team members had an

understanding on how to protect people's confidentiality and private information. And they separated confidential waste for shredding offsite. A privacy notice was clearly displayed in the retail area for people to read and a leaflet describing how the pharmacy protected people's private information was available.

Team members had completed safeguarding training appropriate to their roles and they understood their role in protecting vulnerable people. 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 team with an appropriate range of skills and experience to support its services. Team members support each other in their day-to-day work. And they have good continuity to cover holidays and absence. They share ideas to enhance the delivery of pharmacy services. They have some opportunities to complete ongoing training. And they receive some informal feedback on their performance.

Inspector's evidence

A full-time pharmacist covered the opening hours with locum pharmacist support when required. The pharmacy team consisted of two full-time pharmacy technicians, a part-time dispenser, and two part-time delivery drivers. At the time of the inspection the regular pharmacist, one of the technicians and the dispenser were on duty. Team members worked well together and ensured people presenting at the pharmacy were not kept waiting. They worked closely with the team at another pharmacy nearby that was owned by the same company. For example, when support was required for planned absences.

The pharmacy had recently changed its PMR system. The team had received basic training prior to the change but some key functions had not been taught. So, team members were learning how to operate the PMR when they had to access a function. This was either through the help tool embedded in the PMR system or by contacting colleagues at the other pharmacy who had undergone the same change. Team members from both pharmacies shared their learnings with each other.

Additional training for team members to keep their knowledge up to date was centred around that required for the NHS Pharmacy Quality Scheme such as infection prevention and control. Team members received informal feedback on their performance. But they didn’t have the opportunity to formally reflect on their performance and identify opportunities to progress and develop their skills. A member of the company’s Human Resource team regularly visited the team to offer support and speak to each team member. The pharmacy technician used this opportunity to ask for additional hours to allow a team member from another pharmacy in the company to work one day a week and manage the retail area.

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, but team members managed the space well and worked in a tidy and organised manner. Dispensing benches were free from clutter to help reduce the risk of errors and floor spaces were generally kept clear to reduce the risk of trip hazards. A few boxes containing completed prescriptions were kept on the floor, but they were stored against a wall. So, they were not significantly impeding the team's ability to walk freely around the dispensary. Team members kept the pharmacy clean with separate sinks in place for handwashing and dispensing of medicines. The pharmacy kept heating and lighting to an acceptable level in the dispensary and retail area.

There was enough storage space for stock, assembled medicines and medical devices. The pharmacy had a defined professional area and items for sale in this area were healthcare related. A small, soundproof consultation room enabled the team to have private conversations with people. The pharmacy prevented unauthorised access to the dispensary during the opening hours.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides a range of services that supports local people's health needs. Overall, it manages its services well to help people receive appropriate care. Team members obtain medicines from reputable sources, and they adequately store and carry out checks on medicines to ensure they are in good condition and appropriate to supply.

Inspector's evidence

Access to the pharmacy was via a small step with handrails located either side of the door. The pharmacy kept a small range of healthcare information leaflets for people to read and to take away. The pharmacy's opening hours were not clearly displayed for people to see and at the time of the inspection were different on the nhs.uk website. This was raised during the inspection and action was taken to get the entry amended. The pharmacy received several referrals to the NHS Community Pharmacist Consultation Service (CPCS) from NHS 111 and local GPs. This enabled people to readily access treatment for a minor illness or an urgent supply of their regular medication.

The pharmacy provided multi-compartment compliance packs to help some people take their medicines. This was mostly managed by one of the pharmacy technicians with support from other team members. To manage the workload prescriptions were ordered in advance especially when the technician was on planned leave. Each person had a record listing their current medication and dose times which prescriptions were checked against. A sample of completed packs showed the descriptions of the products within the packs were not always recorded, occasionally a handwritten description was added. So, people would not be able to identify all the medicines in the packs. Team members reported they were learning how to print the descriptions from the new PMR system. The manufacturer's packaging leaflets were supplied so people had information about their medicines. Occasionally the pharmacy received copies of hospital discharge summaries. Every three months team members contacted the person who received the packs or their representative. And they reminded people to inform the pharmacy about any hospital admissions or discharges.

People were provided with clear advice on how to use their medicines. Team members were aware of the criteria of the valproate Pregnancy Prevention Programme (PPP). And a completed audit on people prescribed valproate identified no-one prescribed valproate met the PPP criteria.

The pharmacy provided separate areas for labelling, dispensing and checking of prescriptions. Baskets were used during the dispensing process to isolate individual people's medicines and to help prevent them becoming mixed up. Pharmacy team members initialled dispensed by and checked by boxes on dispensing labels, to record their actions in the dispensing process. When the pharmacy didn't have enough stock of someone's medicine, it provided a printed slip detailing the owed item. The pharmacy kept a record of the delivery of medicines to people for team members to refer to if queries arose.

The pharmacy ordered and obtained most of its medicines from the company's head office. The team followed a detailed process to order the medication and received information from the head office team about delays with the supply of medication ordered. So, the team could advise the person. Team members mostly followed the SOPs to ensure the medicines were safe to supply. This included regular checks of the expiry dates on stock and keeping a record of this activity. But a sample of medicines with

short expiry dates were not marked to prompt team members to check the medicine was still in date. No out-of-date stock was found. The dates of opening were recorded for medicines with altered shelf-lives after opening so team members could assess if the medicines were still safe to use. The team reported that fridge temperatures were checked each day but a record had not been made since March 2023 when the PMR system had changed. The fridge temperature at the time of the inspection was within range. 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 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 received alerts about medicines and medical devices from the Medicines and Healthcare products Regulatory Agency (MHRA) via email. The team usually 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 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 resources and access to the internet to provide the team with up-to-date clinical information. It had equipment available for the services provided including a range of CE equipment to accurately measure liquid medication. And a fridge for holding medicines requiring storage at this temperature.

The pharmacy's computers were password protected and access to people's medication records were restricted by the NHS smart card system. Team members used cordless telephones to help ensure their conversations with people were held in private. They stored completed prescriptions away from public view and they held other confidential information in the dispensary which had restricted public access.

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.