General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Batley Pharmacy, 157 Upper Commercial Street, BATLEY, West Yorkshire, WF17 5DH

Pharmacy reference: 1090774

Type of pharmacy: Community

Date of inspection: 22/04/2021

Pharmacy context

The pharmacy is in the suburbs of Batley town centre. It is open 100 hours per week over seven days. Pharmacy team members dispense NHS prescriptions and sell a range of over-the-counter medicines. They offer services including seasonal flu vaccinations and emergency contraception. The pharmacy provides medicines to people in multi-compartment compliance packs. And it delivers medicines to people's homes. It provides a substance misuse service, including supervised consumption and needle exchange. Conditions on registration are in place at this pharmacy premises. These conditions were imposed after failings were identified at a previous inspection and they remain in force at the time of this inspection. The pharmacy was inspected during the Covid-19 pandemic.

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 has relevant procedures to identify and manage risks to its services. It protects people's confidential information. And it keeps the records it must by law. Pharmacy team members know how to help safeguard the welfare of children and vulnerable adults. They regularly record and discuss mistakes that happen when dispensing. And they make changes to help reduce the risks.

Inspector's evidence

The pharmacy had a set of standard operating procedures (SOPs) in place for the services it provided. The sample checked were last reviewed in June and July 2020. The pharmacy had implemented specific SOPs to help them manage the risks of the Covid-19 pandemic. There were records available to confirm that pharmacy team members had read and understood the procedures. The pharmacy had completed and documented a risk assessment to help pharmacy team members manage the risks of the Covid-19 pandemic. And it had completed individual risk assessments for each pharmacy team member to establish people's individual risks and how best they could be managed. Pharmacy team members explained the measures they had implemented to manage the risks to everyone and help protect more vulnerable team members. These measures included closing the pharmacy's retail area to the public and serving people using a separate entrance and room that had previously been dedicated to helping people receiving supervised consumption of the medicines. The pharmacy was restricting access to the room to one person at a time. And pharmacy team member spoke to people from behind a plastic screen. Pharmacy team members wore masks all the time while they were at work. And they regularly washed their hands and used hand sanitiser. They regularly cleaned surfaces and high-frequency touch points in the pharmacy. Pharmacy team members were also able to mostly maintain social distancing while they worked. They were each conducting a lateral flow test twice a week and actioned the results appropriately.

During the pandemic, the pharmacy had continued to provide seasonal flu vaccinations and emergency contraception to people. The pharmacist explained that a risk assessment had been carried out to determine the risks of each service. But she could not find the documented assessments during the inspection. The pharmacy had put measures in place to manage the risks of spreading Covid-19 while providing flu vaccinations. These included asking people if they had any Covid-19 symptoms when they arrived at the pharmacy. Measures also included making sure people were able to remain socially distanced up to the point of their vaccination. And ensuring that pharmacy team members were wearing the correct personal protective equipment (PPE). At the height of the pandemic, the pharmacists were providing emergency contraception consultations with people over the phone. If it was necessary to provide emergency contraception, people came to the pharmacy to receive their medicine. They were asked to confirm their identity, to make sure they matched the details they gave during their phone consultation.

The pharmacist highlighted near miss errors made by pharmacy team members when dispensing. These errors were recorded by the pharmacist or the pharmacy team member who had made the error. They discussed the errors made at a monthly meeting. From the records seen, there were more errors recorded than at the last inspection. A dispenser explained the team was taking more time to record and consider each mistake they made to help them learn. Some information recorded by pharmacy team members was vague about why they had made a mistake. But they explained that these causes

were often explored further at their monthly meetings. A nominated dispenser was responsible for analysing the data collected about mistakes each month. And he kept records of his analyses. The records captured the general points of the analysis and what had been discussed at each meeting. The pharmacy had a process for dealing with dispensing errors that had been given out to people. It recorded incidents using a template reporting form. Pharmacy team members discussed errors and made changes to prevent recurrence. One recent example was an error where someone had received loratadine instead of lamotrigine. The report gave information about what had happened. But there was little information about what had caused the error. Pharmacy team members explained they had recently reorganised the medicines in the dispensary to help better separate look-alike and sound-alike (LASA) medicines. For example, different strengths of sertraline were now kept on different shelves. And sildenafil was kept further away to help prevent them being picked in error. Since the last inspection, pharmacy team members felt more comfortable recording and discussing errors they made. And they were clear that the process was to help them learn and change things to make the pharmacy safer.

The pharmacy had a procedure to deal with complaints handling and reporting. It had a practice leaflet available for customers in the retail area which clearly explained the company's complaints procedure. It collected feedback from people by using questionnaires.

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 pharmacy team members audited these against the physical stock quantity every two to four weeks and after each entry made in the register. They audited methadone registers weekly. The pharmacy kept and maintained a register of CDs returned by people for destruction. And this was complete and up to date. The pharmacy maintained a responsible pharmacist electronically. And this was complete and up to date. The pharmacist displayed their responsible pharmacist notice to people. Pharmacy team members monitored and recorded fridge temperatures twice a day 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. It shredded confidential waste. Pharmacy team members had been trained to protect people's privacy and confidentiality by reading a folder of information, which included the pharmacy's General Data Protection Regulation (GDPR) policy. And they had attended an in-house training session in February 2021. The pharmacy had appointed a dispenser to oversee information governance (IG) in the pharmacy. She said that everyone had read the information in the folder approximately six months ago. Pharmacy team members were clear about how important it was to protect confidentiality.

A pharmacy team member gave a clear explanation of how they would raise concerns about vulnerable children and adults. The pharmacy had a procedure supporting information in place instructing pharmacy team members where to raise their concerns and how to obtain advice. And it had up-to-date contact information for local safeguarding teams displayed. The pharmacist had completed training about safeguarding in 2019. Other pharmacy team members had completed formal training in December 2020.

Principle 2 - Staffing ✔ Standards met

Summary findings

Pharmacy team members have the right qualifications and skills for their roles and the services they provide. They regularly complete training. And they learn from the pharmacist and each other to keep their knowledge and skills up to date. Pharmacy team members feel comfortable making suggestions. And the pharmacy responds by making changes to help improve its services.

Inspector's evidence

Pharmacy team members explained that recently working in the pharmacy had improved greatly. And the managers were there to support them. The pharmacy had provided new, revised standard operating procedures. And a regular structured training programme for team members to follow. Pharmacy team members explained that the manager had discussed their roles with them one-to-one. And he had used their information to reassess the pharmacy's staffing levels. As a result, the pharmacy had recruited an apprentice training towards a qualification in pharmacy services to help reduce individual's workload. And to give people more time to complete their tasks. Pharmacy team members also explained they had reassessed each person's tasks. This had led to a fairer distribution of tasks. And people being nominated to lead in various areas of the business. For example, one person had been appointed to coordinate training. And another person to oversee the collection and analysis of errors. Pharmacy team members felt much more comfortable with their new way of working. And confident they could complete their tasks well.

Pharmacy team members were enrolled on an online training programme provided by a trade organisation. They completed at least one training module every month. And these modules covered various subjects. Pharmacy team members had also recently completed several training modules available via Public Health England. The recent topics included weight management and antimicrobial resistance. The pharmacy manager and training coordinator regularly encouraged team members to complete their required training using both platforms. And the pharmacy manager monitored completion of their training. Pharmacy team members received an appraisal with their manager every year, with a monitoring review every three months to establish their progress. They discussed their performance and identified any learning needs. They set objectives to help them achieve their goals. A recent example of an objective was for a pharmacy team member to become a healthy living pharmacy champion. She had been supported by colleagues and her manager. And had recently achieved her accreditation.

A dispenser felt comfortable to raise professional concerns with any of the pharmacy's three managers or the superintendent pharmacist (SI). And confident that his concerns would be considered, and changes would be made where they were needed. The pharmacy had a whistleblowing policy. And pharmacy team members were aware of how to access the procedure. The pharmacy team communicated with an open working dialogue during the inspection. Pharmacy team members had changed the layout of medicines in the dispensary after discussing the errors they had made. And after

discussing and identifying possible solutions to reduce the number of mistakes involving look-alike and sound-alike medicines.

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 passageways were 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. The pharmacy had a separate room that was currently being used to speak to people to prevent them accessing the rest of the pharmacy. The room had an entrance from the street. It was tidy and clean. And there was a plastic screen in place to help prevent the spread of coronavirus.

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. Heat and light in the pharmacy were maintained to acceptable levels. The pharmacy’s overall appearance was professional, including the exterior which portrayed a professional healthcare setting.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's services are easily accessible to people, including people using wheelchairs. The pharmacy has systems in place to help provide its services safely and effectively. It sources its medicines appropriately. And it mostly stores and manages its medicines properly.

Inspector's evidence

The pharmacy had level access from the street into a large retail area via automatic doors. To help prevent the transmission of coronavirus, the pharmacy had restricted access to this area of the pharmacy. It was currently asking people to use a side entrance to access a room where people could speak to pharmacy team members through a plastic screen. People accessed the room via steps from the street. And there was a bell to attract pharmacy team members' attention. The pharmacy was restricting access to this area to one person at a time. Pharmacy team members explained that people who could not the steps could ring a bell at the pharmacy's main entrance. And someone would respond to help them by allowing them to access the pharmacy's main retail area. The pharmacy's services were advertised on a banner attached to the wall outside the pharmacy, which could be seen when the pharmacy was closed. Pharmacy team members prepared prescriptions in the dispensary at the back of the pharmacy. They used written communication to help people with a hearing impairment. And there was a hearing induction loop available. Pharmacy team members were unsure about how they would help people with a visual impairment. Some pharmacy team members could speak other languages spoken by people in the local community. These included Punjabi, Urdu, Gujarati and Russian.

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 pharmacist counselled people receiving prescriptions for valproate if appropriate. And she said she would check if the person was aware of the risks if they became pregnant while taking the medicine. She advised she would also check if they were on a pregnancy prevention programme. The pharmacy had a stock of printed information material to give to people and to help them manage the risks. 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 what the medicines looked like, so they could be identified in the pack. And they provided people with patient information leaflets about their medicines each month. Pharmacy team members documented any changes to medicines provided in packs on the patient's master record sheet. The pharmacy delivered medicines to people. It recorded the deliveries made. Pharmacy team members highlighted bags containing controlled drugs (CDs) to the delivery driver. 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. During the pandemic, the delivery drivers were placing a package on a doorstep, knocking on the door and moving back to a safe distance to watch someone accept the delivery and confirm their identity.

The pharmacy obtained medicines from licensed wholesalers. It stored medicines tidily on shelves. And it kept all stock in restricted areas of the premises where necessary. The pharmacy had adequate disposal facilities available for unwanted medicines, including CDs. Pharmacy team members kept the

CD cabinet tidy and well organised. And they segregated out-of-date and patient-returned CDs. The inspector checked the physical stock against the register running balance for two products. And these were correct. Pharmacy team members kept the contents of the pharmacy fridges tidy and well organised. They monitored the minimum and maximum temperatures in the fridge twice a day. And they recorded their findings. The temperature records seen were within acceptable limits.

Pharmacy team members checked medicine expiry dates every eight weeks. And up-to-date records were seen. Pharmacy team members highlighted any short-dated items with a coloured sticker on the pack up to six months in advance of its expiry. And they removed items from the shelves if they expired before the next date check. Pharmacy team members also used packs with stickers attached first to help prevent wastage. During a brief search of the shelves, the inspector found three amber bottles that contained medicines that had been removed from their original packaging. Two of these bottles were labelled but did not contain the necessary batch number and expiry dates of the medicine. The third did not have a label attached. This was discussed with the pharmacist. She removed the bottles and disposed of the contents immediately. And gave her assurance that bottles would be labelled correctly in the future. The pharmacy responded to drug alerts and recalls. It quarantined any affected stock found for destruction or return to the wholesaler. It recorded any action taken. And records included details of any affected products removed.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the necessary equipment available for its services, which it properly maintains. And it manages and uses the 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 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 liquid medicines preparation. It positioned computer terminals away from public view. And these were password protected. The pharmacy stored medicines waiting to be collected in the dispensary, also away from public view. It had two dispensary fridges that were in good working order. Pharmacy team members restricted access to all equipment. And they stored all items securely. The pharmacy had the necessary equipment to help team members manage the risks of coronavirus. These resources included face masks, gloves, hand sanitiser and equipment to clean hands and surfaces regularly.

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.