General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: 1st Pharmacy, Fountain Hall, Fountain Street, BRADFORD, West Yorkshire, BD1 3RA

Pharmacy reference: 1091138

Type of pharmacy: Community

Date of inspection: 09/05/2019

Pharmacy context

The pharmacy is in Bradford city centre. It is open 100 hours per week. And, it is open seven days a week. The pharmacy team mainly dispenses NHS prescriptions and sells a range of over-the-counter medicines. The pharmacy offers services including medicines use reviews (MUR), the NHS New Medicines Service (NMS) and emergency dispensing of medicines via the NHS Urgent Medicines Supply Advanced Service (NUMSAS). The pharmacy team members provide a substance misuse service, including supervised consumption, and needle exchange. The pharmacy provides multi-compartmental compliance packs to people living in their own home.

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 procedures to identify and manage risks. It keeps them up to date. The pharmacy has systems in place to manage any complaints it receives from people using its services. And it maintains the pharmacy records it must by law. But it doesn't keep a record of how much it has in stock for all the medicines it should. So, the team can't check the record is correct and may not know if there are any errors or losses. Pharmacy team members read and follow the procedures. They keep people's private information secure. They know how to protect the welfare of children and vulnerable adults. And, they relate this to people using their services. The team members record and discuss mistakes that happen. They use this information to learn and make changes to help prevent similar mistakes happening again. But they don't always discuss or record enough detail about why these mistakes happen. So, they may miss opportunities to improve.

Inspector's evidence

The pharmacy had a separate area it used to provide services to people using substance misuse services. And, they spoke to staff and received their medication through a hatch. The pharmacist explained this was to help protect the privacy of patients. She said patients were given the choice to use the segregated area or to use the main pharmacy retail area.

The pharmacy had a set of standard operating procedures (SOPs) in place. The superintendent pharmacist (SI) had reviewed the procedures in June 2017. And had scheduled the next review of the procedures for June 2019. Pharmacy team members had read and signed the SOPs since the last review. The pharmacy defined the roles of the pharmacy team members in each SOP. Comprehensive procedures were in place for dispensing and providing controlled drugs in instalments to people using the substance misuse service.

The pharmacist highlighted and recorded near miss errors made by the pharmacy team when dispensing. The pharmacy team discussed the errors made. But, they did not record much detail about why a mistake had happened. The pharmacist analysed the data collected about mistakes every month. But, she said the analysis was not recorded. So, she could not reflect on the changes made last month to see if they had reduced the type of errors identified. The pharmacy had separated different brands of buprenorphine tablets in the controlled drugs (CD) cabinet. And, this was to prevent mistakes when selecting medicines after an error had been made. 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. But, the records did not always record details about why an error had happened or what had been done to prevent it happening again. One example was given of the team members having dispensed a post-dated prescription early. They had changed the way they stored post-dated prescriptions to segregate them from current ones. And, they highlighted the date on the prescription to make people aware they were post-dated.

Pharmacy team members used a communications book to communicate key information between people working on different shifts. They looked at the book at the beginning of their shift to help them know the key tasks that needed to be dealt with.

The pharmacy had a procedure to deal with complaints handling and reporting. But, it did not advertise

the company complaints procedure to people in the retail or substance misuse service area. It collected feedback from people by using questionnaires. And, it had feedback available from the last set of questionnaires to be analysed. One improvement point was having somewhere to speak to staff privately, despite there being a consultation room available. In response, they had updated signs outside the pharmacy. And, this told people there was a private consultation room available. The pharmacy team had also received verbal feedback that people could not see the pharmacy at night. So, they had installed new lighted signage. And, more clearly displayed their opening times.

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 most registers. And they were audited against the physical stock quantity weekly. But, it did not keep a running balance for sugar free methadone. And, this was the product they dispensed most often in large quantities. It kept and maintained a register of CDs returned by people for destruction. And it was complete and up to date. The pharmacy maintained a responsible pharmacist record on paper. And it was complete and up to date. The pharmacist displayed their responsible pharmacist notice to people. The pharmacy team monitored and recorded fridge temperatures daily. 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. The pharmacy dispensed a high volume of emergency supplies via the NHS NUMSAS service. The pharmacist said this was because they were in the city centre. And were open for 100 hours per week. All NUMSAS transactions were recorded as an emergency supply.

The pharmacy kept sensitive information and materials in restricted areas. It positioned computer terminals away from public view. And they were password protected. It provided a segregated area to help protect the privacy of people accessing substance misuse services. It stored medicines waiting to be collected in the dispensary, also away from public view. And, it shredded confidential waste. The pharmacy team had been trained to protect privacy and confidentiality. They said they had completed online training on the General Data Protection Regulations (GDPR) in 2018. But they had not kept a record of their training. 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 (GDPR). They were also currently assessing the pharmacy for GDPR compliance.

When asked about safeguarding, a dispenser gave some examples of symptoms that would raise their concerns. He gave an example of being aware of patients at risk of overdose. He explained how they would refer to the pharmacist. The pharmacist said they would assess the concerns. And would refer to local safeguarding teams, the person's substance misuse key-worker or GP if appropriate. The pharmacy had contact details available for the local safeguarding service. Pharmacy team members had completed distance learning via the Centre for Pharmacy Postgraduate Education (CPPE) in December 2018 and January 2019.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy team members have the right qualifications and skills for their roles and the services they provide. They complete ad-hoc training, but don't have a regular training plan. And the pharmacy doesn't formally discuss team members performance or training needs. So, they may not keep their knowledge and skills up to date.
Pharmacy team members do not always establish and discuss specific causes of mistakes. This means they may miss chances to learn from errors and make the most effective changes to make pharmacy services safer.

Inspector's evidence

At the time of the inspection, the pharmacy team members present were a pharmacist and a dispenser. Pharmacy team members completed training ad-hoc by reading various trade press and training materials received in the post or by email. And, by having regular discussions with the pharmacists about current topics and attending local training events. But, training activities were not recorded to help give assurances that skills were being kept up to date. The pharmacy did not have an appraisal or performance review process. The dispenser said that any needs he had would be discussed with the pharmacist informally and they would support him to achieve his goals. And they would provide training or signpost to the most appropriate reference source.

The dispenser explained that he would raise professional concerns with the pharmacist or superintendent pharmacist (SI). He said he felt comfortable raising a concern. And confident that his concerns would be considered, and changes would be made where they were needed. The pharmacy did not have a whistleblowing policy. So it may be difficult to raise concerns anonymously.

The pharmacy team communicated with an open working dialogue during the inspection. The dispenser said he was told by the pharmacist when he had made a mistake. The discussion that followed did not fully explore why he had made the mistake. But, he said he would always try and change something to prevent the mistake happening again, such as moving products on the shelves to prevent picking errors.

Pharmacy team members explained a change they had made after they had identified areas for improvement. The dispenser explained he was in the process or designing a new system for storing the different types of prescriptions dispensed, such as prescriptions waiting for delivery, those waiting for people to collect and substance misuse service prescriptions. He said this was to try and make prescriptions and dispensed medicines easier to find. The pharmacy owners and superintendent pharmacist did not ask the team to achieve any targets.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean and properly maintained. It provides a suitable space for the services provided. The pharmacy has a room where people can speak to pharmacy team members privately. And, it uses a dedicated area to help protect the privacy of people using different services and to protect the safety of staff.

Inspector's evidence

The pharmacy was clean and well maintained. All areas of the pharmacy were tidy and well organised. And the floors and passage ways were free from clutter and obstruction. There was 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 separate area for supervising substance misuse prescription doses and providing needle exchange. And, this was accessed through a hatch.

The pharmacy had a private consultation room available. The pharmacy team used the room to have private conversations with people. The room was signposted by a sign on the door.

There was a clean, well maintained sink in the dispensary used for medicines preparation. There was a WC which provided a sink with hot and cold running water and other facilities for hand washing. Heat and light in the pharmacy was maintained to acceptable levels. The overall appearance of the premises was professional, including the exterior which portrayed a professional healthcare setting. The professional areas of the premises were well defined by the layout and well signposted from the retail area.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy is accessible to people. And it generally provides its services safely and effectively. It stores, sources and manages its medicines safely. The pharmacy team members dispense medicines into devices to help people remember to take them correctly. They provide information with these devices to help people know when to take their medicines and to identify what they look like. But, they do not regularly provide people with medicines information leaflets. So, people may not have correct information they need to help them take their medicines safely. The pharmacy team takes steps to identify people taking some high-risk medicines. And they provide people with some advice.

Inspector's evidence

The pharmacy was accessible via level access from the pavement. But there was no bell or signage to tell people how to get staff attention if the needed assistance. Pharmacy team members said they would communicate in writing with someone with hearing impairment. But, they were unsure about how to help someone 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.

The pharmacy supplied medicines in multi-compartmental compliance packs when requested. It provided descriptions of the medicines supplied on the packaging. But, people were not regularly provided with patient information leaflets about their medicines. The pharmacy team documented any changes to medicines provided in packs on the patient's electronic record when a new prescription was dispensed. But, no other information was recorded about a change, such as who had initiated the change and when the team were informed.

The pharmacy team used dispensing baskets throughout the dispensing process to help prevent people's prescriptions being mixed up.

Pharmacy team members checked medicine expiry dates every month. And records were seen. They highlighted any short-dated items with a sticker on the pack up to six months in advance of its expiry. And any stock expiring was removed in the month before its expiry. The pharmacy responded to drug alerts and recalls. And, any affected stock found was quarantined for destruction or return to the wholesaler. The pharmacist said alerts were received electronically. But, they did not record any action taken in response to an alert unless they had found affected stock.

The pharmacy obtained medicines from five licensed wholesalers. It stored medicines tidily on shelves. And all stock was kept in restricted areas of the premises where necessary. It had adequate disposal facilities available for unwanted medicines, including controlled drugs (CDs). The pharmacy team kept the contents of the pharmacy fridge tidy and well organised. They monitored minimum and maximum temperatures in the fridge every day. And they recorded their findings. The temperature records seen were within acceptable limits.

People receiving prescription for sodium valproate were counselled by the pharmacist if appropriate. And, he said he would check if they were aware of the risks to pregnancy while taking the medicine. He

said he would also check if they were on a pregnancy prevention programme. The pharmacy had some printed information material to give to people and to help highlight the medicine during dispensing.

Pharmacy team members were aware of the Falsified Medicines Directive (FMD) to help prevent counterfeit medicines. But, it did not have the right software or scanners to check products. And, there were no procedures and pharmacy team members had not been trained. So, the pharmacy was not complying with current law.

The pharmacy delivered medicines to people. It recorded the deliveries made and asked people to sign for their deliveries. The team highlighted bags containing CDs with a sticker on the bag and on the driver's delivery sheet. And, CD deliveries were signed for on a separate, itemised delivery record.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the necessary equipment available, 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 team obtained equipment from the licensed wholesalers used. And they had a set of clean, well maintained measures available for medicines preparation. They used a separate set of measures and a pump to dispense methadone. The methadone pump was cleaned every day and was calibrated weekly. They did not keep records of calibration. But, they were able to clearly explain the calibration process. And, they said they did regular spot checks of the pump by dispensing a quantity of methadone in to a measure to make sure the amount was accurate. The dispensary fridge was in good working order. And the team used it to store medicines only. Access to all equipment was restricted and all items were stored 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.