

Registered pharmacy inspection report

Pharmacy Name: Mixenden Pharmacy, Mixenden Stones Surgery,
Mixenden Road, HALIFAX, West Yorkshire, HX2 8RQ

Pharmacy reference: 1091772

Type of pharmacy: Community

Date of inspection: 12/02/2020

Pharmacy context

The pharmacy is adjacent to a satellite surgery in a residential area in Mixenden. Pharmacy team members dispense NHS prescriptions and sell a range of over-the-counter medicines. They offer services including medicines use reviews (MURs) and the NHS New Medicines Service (NMS). They supply medicines to people in multi-compartment compliance packs. And deliver medicines to people's homes. The pharmacy provides a substance misuse service, including supervised consumption and needle exchange.

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 to its services. And pharmacy team members generally follow the pharmacy's written procedures to complete the required tasks. The pharmacy 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 discuss mistakes that happen when dispensing. But they don't regularly record details of their mistakes and why these happen. So, they may miss opportunities to improve and reduce the risk of further errors.

Inspector's evidence

The pharmacy had a set of standard operating procedures (SOPs) in place. The sample of procedures seen did not contain any information about when they had last been reviewed. Or when they were due to be reviewed next. Records were available that some pharmacy team members had read and understood the procedures in 2019. But not all pharmacy team members had signed to confirm this. The pharmacy defined the roles of the pharmacy team members in each SOP. And by having further discussions about tasks each day.

The pharmacist highlighted and recorded near miss errors made by the pharmacy team when dispensing. But very few errors had been recorded prior to January 2020. Pharmacy team members discussed the errors made. They did not discuss or record much detail about why a mistake had happened. They usually said rushing or misreading the prescription had caused the mistakes. And, their most common change after a mistake was to double check or to take more care next time. They did not know if the superintendent pharmacist (SI) analysed the data collected for patterns of errors. They explained they had recently highlighted several look-alike and sound-alike medicines by attaching warning stockers to the shelves where the medicines were kept. This was to highlight the risks and to prevent making a picking error while dispensing. They explained the medicines highlighted had been identified as at risk by data collected and shared by the national error reporting system. 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. The examples of records seen captured information about what had happened. But there was little or no information about why the mistake had happened. Or what had been changed to help prevent it happening again. Pharmacy team members could not give any examples of any changes made after a dispensing error had happened.

The pharmacy had a procedure to deal with complaints handling and reporting. It had a poster available for customers in the retail area which clearly explained the company's complaints procedure. It collected feedback from people by using questionnaires. One example of feedback received was about how long it took pharmacy team members to serve people. Team members explained they now made sure the acknowledged someone as soon as they came in to the pharmacy, even if it was to ask them to wait while they finished the job they were doing.

The pharmacy had up-to-date professional indemnity insurance in place. It had a certificate of insurance displayed. The pharmacy kept controlled drug (CD) registers complete and in order. It kept running balances in all registers. And these were audited against the physical stock quantity after each entry in the register. Registers of CDs not used frequently were not regularly audited. For example, the register

for MST 5mg tablets had last been audited in July 2019. And the inspector found a discrepancy in the register during the inspection. The SI quickly rectified the discrepancy. Pharmacy team members audited methadone registers monthly. 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 record on paper. And it was complete and up to date. The pharmacist displayed their responsible pharmacist notice to people. Pharmacy team members monitored and recorded fridge temperatures daily. They kept private prescription records and records of emergency supplies of medicines electronically, which were complete and in order. 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 privacy and confidentiality. The SI had delivered the training verbally about the General Data Protection Regulations (GDPR) in 2018. Pharmacy team members were clear about how important it was to protect confidentiality. The pharmacy did not have a documented procedure available for privacy or information governance to help guide pharmacy team members about best practice. When asked about safeguarding, a dispenser gave some examples of symptoms that would raise their concerns in both children and vulnerable adults. They explained how they would refer their concerns to the pharmacist. The pharmacist said they would assess the concern. And would refer to the SI and local safeguarding teams for advice. The pharmacist had last trained in January 2020. And she renewed her training every two years. The pharmacy did not provide any formal training for other team members. But they had an adequate knowledge of how important it was to help protect vulnerable people. The pharmacy had printed information about some signs and symptoms of abuse in children and adults. And this was kept in the SOP file. But it did not have a documented procedure to instruct pharmacy team members about what to do in the event of a concern about a child or vulnerable adult.

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 complete ad-hoc training. And they regularly learn from the pharmacist and each other to keep their knowledge and skills up to date. Pharmacy team members feel comfortable making suggestions to help improve pharmacy services. The pharmacy considers their suggestions. And it makes changes to help improve the way its services are delivered.

Inspector's evidence

At the time of the inspection, the pharmacy team members present were a pharmacist and two dispensers. The superintendent pharmacist (SI) also worked at the pharmacy regularly each week. Pharmacy team members completed training ad-hoc by reading various trade press materials. And by having regular discussions with both pharmacists about current topics. They sometimes completed training modules in magazines that were accompanied by a quiz. Pharmacy team members completed the quiz. And the SI marked their answers. If they had answered a question incorrectly, they revisited the training article and discussed the topic further with the SI to help improve their understanding. One recent example had been a module about dry skin. Pharmacy team members explained that the SI often spot-tested them about a topic throughout the working day. For example, he would ask them to explain what WHAM stood for. They said they enjoyed having regular, light-hearted discussions about various topics as they worked to help keep their knowledge up to date. Pharmacy team members had an appraisal each year with the SI. The SI discussed their performance. And how well the pharmacy was performing overall. The SI did not set any objectives. Pharmacy team members said they would raise any learning needs with the SI informally. And both pharmacists would support them with teaching and by signposting them to relevant resources.

The dispenser explained she would raise professional concerns with the pharmacist, superintendent pharmacist (SI) or colleagues. She felt comfortable raising a concern. And confident that her concerns would be considered, and changes would be made where they were needed. The pharmacy had a whistleblowing policy. But pharmacy team members were not aware of the procedure. Pharmacy team members communicated with an open working dialogue during the inspection. They explained a change they had made after they had identified areas for improvement. They noticed they had some patients with very similar names. And they identified and discussed the risks of dispensing medicines to the wrong person. They decided to complete a third check during the dispensing process, after medicines had been dispensed, assembled and checked by the pharmacist. After the pharmacist had completed their check, the prescriptions and medicines were passed to a dispenser to place in a bag. As they did so, they checked the prescription matched the bag label. And that the name on the medicine label matched the name on the prescription. They also checked the medicines against the prescription, before placing items in the bag. Pharmacy team members explained they had identified near-miss errors at this stage since it was introduced. The SI 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 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 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 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 toilet 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'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 safely. And it adequately stores and manages its medicines. The pharmacy dispenses medicines into devices to help people remember to take them correctly. And pharmacy team members adequately manage this service. But they don't always provide people with the information they may need to help them understand or make choices about their medicines. Pharmacy team members deliver medicines to people's homes. They keep some records of the deliveries they make. But they don't always keep a complete audit trail of the deliveries. So, it may be difficult to effectively resolve any queries.

Inspector's evidence

The pharmacy had level access from a car park. It advertised some of its services in the retail area. Pharmacy team members were aware of the importance of communicating clearly with people, especially with those with specific communication needs. For example, they explained they would use written communication to help someone with a hearing impairment. And they were able to provide large print labels to help people with a 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. 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. She checked if the person was aware of the risks if they became pregnant while taking the medicine. And she referred people to their GP if she had any issues or concerns. But she did not routinely check if someone was enrolled on a pregnancy prevention programme. This was discussed. And she gave an assurance that she would refresh her knowledge of the necessary requirements. The pharmacy had a stock of printed information material to give to people to help them manage the risks. The pharmacy supplied medicines in multi-compartment compliance packs when requested. It attached backing sheets to the packs, so people had written instructions of how to take the medicines. Pharmacy team members usually included descriptions of what the medicines looked like, so they could be identified in the packs. They provided people with patient information leaflets about their medicines when a medicine was first prescribed. But they did not routinely supply leaflets to people after that. The inspector discussed with the team the importance of providing leaflets regularly. And to make sure people had easy access to information to make an informed choice about their medicines. They gave an assurance that they would immediately provide leaflets regularly to people receiving packs. The pharmacy team documented any changes to medicines provided in packs on each patient's master record sheet. The pharmacy delivered medicines to people. It recorded the deliveries made. But it did not ask people to sign for their deliveries. So, there was no robust audit trail of the delivery service. The pharmacy asked people to sign for controlled drugs (CDs) on an itemised docket. 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. The team highlighted bags containing CDs on the driver's delivery sheet.

The pharmacy stored medicines tidily on shelves. And all stock was kept in restricted areas of the premises where necessary. Pharmacy team members had some knowledge of the requirements of the Falsified Medicines Directive (FMD) introduced in February 2019. The pharmacy did not have any

equipment, software or procedures in place to comply with the requirements. Pharmacy team members said the superintendent pharmacist was currently negotiating with software suppliers to implement the necessary equipment. They did not know a timescale for implementation. The pharmacy had adequate disposal facilities available for unwanted medicines, including CDs. Pharmacy team members kept the CD cabinet tidy and well organised. And, out of date and patient returned CDs were segregated. The inspector checked the physical stock against the register running balance for three products. And these were correct. Pharmacy team members checked medicine expiry dates every six months. 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. But removing these items relied on pharmacy team members seeing the stickers if they expired before the next scheduled date check. The pharmacy responded to drug alerts and recalls. And, any affected stock found was quarantined for destruction or return to the wholesaler. It recorded any action taken. And, records included details of any affected products removed. Pharmacy team members 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.

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 had a set of clean, well maintained measures available for medicines preparation. The pharmacy positioned computer terminals away from public view. And these were password protected. It stored medicines waiting to be collected in the dispensary, also away from public view. The pharmacy had a dispensary fridge, which was in good working order. And, pharmacy team members used it to store medicines only. They restricted access to all equipment, and they stored all items 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.