General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Oakenshaw Pharmacy, 673 Bradford Road, Oakenshaw, BRADFORD, West Yorkshire, BD12 7DT

Pharmacy reference: 1094421

Type of pharmacy: Community

Date of inspection: 10/02/2022

Pharmacy context

The pharmacy is on a main road in Oakenshaw. Pharmacy team members dispense NHS prescriptions and sell a range of over-the-counter medicines. They provide medicines to people in multi-compartment compliance packs. And they deliver medicines to people's homes. The pharmacy provides a substance misuse service. The inspection was completed during the COVID-19 pandemic.

Overall inspection outcome

Standards not all met

Required Action: Improvement Action Plan

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 not all met	1.2	Standard not met	Pharmacy team members do not follow the pharmacy's processes and record the mistakes they make during dispensing. And there is no evidence of recent learning from these mistakes to help improve the safety and quality of the pharmacy's services.
		1.6	Standard not met	The pharmacy does not keep the necessary robust and accurate records to help ensure the safety and quality of its services. And to comply with current legal requirements.
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 not all met	4.3	Standard not met	The pharmacy does not always store medicines that require refrigeration in appropriate conditions. And it does not have suitable systems in place to make sure pharmacy team members store these medicines appropriately.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance **Standards not all met**

Summary findings

The pharmacy does not adequately and routinely assess the safety and quality of its services. Pharmacy team members do not record or analyse their mistakes. So, they may miss opportunities to learn and make services safer. The pharmacy does not keep the necessary robust records to help ensure it is providing its services safely and effectively. And to comply with the law. Pharmacy team members suitably protect people's confidential information. And they know how to help protect vulnerable people.

Inspector's evidence

The pharmacy had a set of standard operating procedures (SOPs) in place. The pharmacy manager had reviewed the procedures in 2017. But he had not reviewed the procedures since. The pharmacy required SOPs to be reviewed every two years. Pharmacy team members had read the procedures after the last review in 2017. And some team members, who had joined the team since then, had also read the procedures and signed to confirm they had understood them. The roles and responsibilities of pharmacy team members were defined in a dedicated SOP. And were recorded in a list for each named individual team member. The pharmacy had assessed the risks of providing services during the Covid-19 pandemic. Pharmacy team members wore masks while they were at work. And they had hand sanitiser available in various locations in the pharmacy to help them maintain good hand hygiene. The pharmacy had installed plastic screens at the retail counter to help prevent the spread of infection.

The pharmacy had a system in place for recording mistakes made by pharmacy team members while they dispensed. But pharmacy team members had not made records of near miss errors since July 2021. Pharmacy team members admitted errors had been made since then. There was no evidence of any learning from errors since July 2021. Or of pharmacy team members making any changes to make the pharmacy safer since then. Pharmacy team members explained they discussed errors together when they were discovered. An example given of a change made to prevent mistakes was prior to July 2021 and had resulted in labels being attached to the edges of shelves to warn team members about look-alike and sound-alike medicines, such as lamotrigine and lercanidipine. The pharmacist had not analysed the data collected about near miss errors to look for patterns since 2018. The pharmacy had a system in place to discuss and record errors that had been given out to people. Pharmacy team members recorded these errors using the NHS Learn from patient safety events (LFPSE) service, formerly known as the National Reporting and Learning Service (NRLS). They printed a copy of the reports to keep in the pharmacy. And the examples seen were detailed about what had happened, the causes and the actions the team had taken to prevent a recurrence. The pharmacy had a documented procedure in place for handling complaints and feedback from people. Pharmacy team members explained feedback was usually collected verbally. And any complaints were referred to the pharmacist to handle. There was no information available for people about how to provide the pharmacy with feedback. The pharmacy had up-to-date professional indemnity insurance in place.

The pharmacy had a fridge in the pharmacy where it stored medicines. But pharmacy team members were not monitoring or recording temperatures in the fridge. So, they were unable to give an assurance that the fridge was keeping medicines at the correct temperatures. The pharmacy had controlled drugs (CD) registers in place. But pharmacy team members were not keeping these up to date. Pharmacy team members kept running balances in the registers. The pharmacy maintained a responsible

pharmacist record. And this was complete and up to date. The pharmacist displayed their responsible pharmacist notice to people. Pharmacy team members kept private prescription and emergency supply records, which were complete and in order.

The pharmacy kept sensitive information and materials in restricted areas. Pharmacy team members segregated confidential waste into pink baskets. And they regularly emptied these and shredded the waste. Pharmacy team members explained how they protected people's privacy and confidentiality. Pharmacy team members had read the pharmacy's SOP about confidentiality and data protection and a file of information governance materials to help them achieve this. They had last completed this in 2017, prior to the introduction of the General Data Protection Regulations (GDPR).

Pharmacy team members gave some examples of symptoms that would raise their concerns about vulnerable children and adults. They referred their concerns to the pharmacist. The pharmacy had a documented procedure explaining how team members should raise their concerns about children and vulnerable adults. And the pharmacy displayed up-to-date information about local safeguarding contacts for people to use. Pharmacy team members had completed training about how to protect vulnerable people in 2020, including the pharmacist.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough team members qualified and in-training to suitably provide its services. Pharmacy team members complete some ongoing training. And they learn from the pharmacist and each other to keep their knowledge and skills up to date. But they don't always have opportunities to complete regular training at work.

Inspector's evidence

At the time of the inspection, the pharmacy team members present were a pharmacist manager, one qualified dispenser and two trainee dispensers. The trainees were not enrolled on appropriate training courses for the roles they were carrying out. And they had both been employed at the pharmacy for more than three months. This was discussed. And after the inspection, the pharmacist provided evidence that both team members had since been enrolled on appropriate dispenser training courses.

Pharmacy team members kept their skills and knowledge up to date by completing e-learning modules ad hoc throughout the year. But they had not completed any of this training recently. They explained this was because they did not have time to spend completing training while at work. They expected to re-establish these opportunities now the pharmacy was stabilising after the pressures at the height of the pandemic. Pharmacy team members discussed topics with the pharmacist and each other. The pharmacy did not have a formal appraisal or performance review process for pharmacy team members. They raised any learning needs verbally with the pharmacist. And he would support them by signposting them to relevant reference sources or by discussing topics to help address their learning needs.

A pharmacy team member explained how they would raise professional concerns with the responsible pharmacist or the superintendent pharmacist (SI). They felt comfortable sharing ideas to improve the pharmacy or raising a concern. And they were confident that their points would be considered. The pharmacy had a whistleblowing policy. But pharmacy team members were unsure about how to access the process. They were aware of organisations outside the pharmacy where they could raise professional concerns, such as the NHS or GPhC. Pharmacy team members communicated with an open working dialogue during the inspection. The pharmacy did not ask pharmacy team members to meet any performance related targets.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is generally clean and properly maintained. It has a suitable room where people can speak to pharmacy team members privately. The pharmacy provides a suitable space for the services it delivers. But there is some clutter that reduces the team's available workspace.

Inspector's evidence

The pharmacy was generally clean and well maintained. But the floor needed mopping and vacuuming. And some shelves used to store medicines were dusty. Most areas of the pharmacy were tidy and well organised. But there were several areas of the benches that were cluttered with items such as dispensing baskets, prepared multi-compartment compliance packs and paperwork. This reduced the amount of bench space available to work from. The pharmacy's floors and passageways were generally free from clutter and obstruction. The pharmacy kept equipment and stock on shelves throughout the premises. It had a cellar which pharmacy team members used for storage, which was suitably hygienic. The pharmacy had a private consultation room available. Pharmacy team members 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, with a sink which provided hot and cold running water and other facilities for hand washing. The pharmacy maintained heat and light to acceptable levels. Its overall appearance was professional, including the pharmacy's exterior which portrayed a professional healthcare setting. The pharmacy's professional areas were well defined by the layout and were well signposted from the retail area.

Principle 4 - Services **Standards not all met**

Summary findings

The pharmacy does not manage and store all its medicines appropriately. It does not have robust processes for monitoring the temperature of medicines it keeps in the fridge. So, some of its medicines may not be fit to use. Pharmacy team members help people to access the pharmacy's services. And they provide some suitable advice to people about their medicines.

Inspector's evidence

People had access to the pharmacy from the street via steps. They knocked on the door to attract attention if they needed help. Pharmacy team members could use the electronic patient medication records (PMR) system to produce large-print labels to help people with visual impairment. They explained how they would use written communication to help people with hearing impairment. And they would lower their masks to enable people to lip read, while standing behind a plastic screen to manage the coronavirus infection risks.

The pharmacy did not have a robust process in place to make sure the fridge was maintaining the appropriate storage conditions for medicines. Pharmacy team members did not regularly monitor or record fridge temperatures in the medicines fridge. They had last recorded a fridge temperature in August 2021. The temperature of the fridge during the inspection was 15.1 degrees Celsius. So, this was outside acceptable limits. Pharmacy team members did not know how long the fridge had been at this temperature. The pharmacy had a second fridge in another room. The fridge was used by pharmacy team members to store food. The inspector found insulin being stored in this fridge. And pharmacy team members did not monitor temperatures in this fridge either. The pharmacy obtained medicines from licensed wholesalers. It stored medicines on shelves. And it kept medicines in restricted areas of the premises where necessary. It had adequate disposal facilities available for unwanted medicines, including controlled drugs (CDs). Pharmacy team members kept the CD cabinet tidy and well organised. And out-of-date and patient-returned CDs were segregated.

The pharmacy had a documented procedure for checking stock for short-dated and expired medicines. Pharmacy team members explained they checked medicines every three months. And they removed any medicines expiring before the next scheduled check. They highlighted short-dated medicines up to six months before their expiry. The pharmacy did not have any records available of any expiry date checking being completed. There was also evidence of some short-dated packs not being highlighted which would help pharmacy team members remove them before they expired. After a search of the shelves, the inspector did not find any out-of-date medicines.

The pharmacy supplied medicines in multi-compartment compliance packs when requested to people in their own homes and people who lived in a care home. 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 packs. But they did not routinely provide people with patient information leaflets about their medicines each month. They provided the care home with leaflets once a year. Pharmacy team members documented any changes to medicines provided in packs on the patient's electronic medication record (PMR). They also used the notes section of the PMR to record conversations they had about people's medicines to help them keep an audit trail of changes. This included notifying the care home of any discrepancies between the

prescriptions they had ordered and what had been received. They pharmacy stored packs waiting to be checked by the pharmacist on a bench. Some packs seen had not been sealed or closed. And this increased the risk of medicines falling out or moving to the wrong compartment. This was discussed and the pharmacist gave his assurance that packs would always be closed for storage.

Pharmacy team members signed the dispensing labels for medicines that were dispensed in the pharmacy. This was to maintain an audit trail of the people involved in the dispensing process. And they used dispensing baskets throughout the dispensing process to help prevent prescriptions being mixed up. The RP counselled people receiving prescriptions for valproate if appropriate. And he checked if the person was aware of the risks if they became pregnant while taking the medicine. He also checked if they were on a pregnancy prevention programme. The pharmacy provided the patient card attached to each original pack of valproate to people. And made sure they did not obscure important safety information with dispensing labels. But it did not have stock of some of the other printed information material available to give to people to help them manage the risks. This was discussed and the RP gave his assurance that he would obtain the outstanding materials as soon as possible. The pharmacy delivered medicines to people. It recorded the deliveries made. 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 to arrange a redelivery.

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 it had available included the British National Formulary (BNF), the BNF for Children, various pharmacy reference texts and use of the internet. The pharmacy had some equipment available to help prevent the transmission of Covid-19. These included hand sanitiser and plastic screens. The pharmacy had a set of clean, well maintained measures available for medicines preparation. It had a suitable shredder available to destroy its confidential waste. It kept its computer terminals in the secure areas of the pharmacy, away from public view. And these were password protected. The pharmacy restricted access to all equipment.

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.